

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03024

CERTIFICATE OF DEATH

03026

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10313 Paerma Rd</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>William</i>		First	Middle	Last	4. DATE OF DEATH <i>March 8 1957</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-13</i>		9. AGE (In years last birthday) <i>43</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Supervisor Amer. Security Trust</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Amer. Security Trust</i>		11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer</i>		
13. FATHER'S NAME <i>Will G. Allen</i>		14. MOTHER'S MAIDEN NAME <i>Lennie Johnson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Washington San. Hospital Records</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i>						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>Primary Carcinoma of R Bronchus</i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7701 Camill Ave</i>		20f. (City or town) (County) (State) <i>Takoma Park MD</i>		
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> , to <i>March 8</i> , 19 <i>57</i> that I last saw the deceased alive on <i>March 7</i> , 19 <i>57</i> , and that death occurred at <i>1130A M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James M. Whitlock</i>				ADDRESS (Street, city or town, state) <i>7701 Camill Ave</i>		DATE SIGNED <i>3-2-57</i>		
PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/11/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>BROOKVILLE METHODIST CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>BROOKVILLE, MARYLAND</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Bumpfrey</i>		ADDRESS <i>Silver Spring</i>		24a. REC'D BY REGISTRAR DATE <i>3/11/57</i>		24b. REGISTRAR'S SIGNATURE <i>John D.</i>		

BUREAU V. 2

MAR 13 1957

REGELV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 16

03027

03057

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easley 77X-3			
d. STREET ADDRESS Route # 2		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Lee	Last Atkinson		
4. DATE OF DEATH	Month March	Day 19	Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 May 1928		
9. AGE (In years last birthday) 28 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canteen Worker	11. KIND OF BUSINESS OR INDUSTRY Food Dispensing	12. BIRTHPLACE (State or foreign country) South Carolina		
13. FATHER'S NAME William L. Atkinson	14. MOTHER'S MAIDEN NAME Annie Carnes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No	16. SOCIAL SECURITY NO 247-36-5220	17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema Aortic Stenosis Rheumatic Heart Disease	INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Easley	(County) South Carolina	(State) MD
21. I certify that I attended the deceased from 17 March , 1957, to 19 March , 1957, that I last saw the deceased alive on 19 March , 1957, and that death occurred at 11.15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edward G. Biglieri M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipment	22b. DATE THEREOF 3/19/57	22c. NAME OF CEMETERY OR CREMATORIUM Easley Cemetery	22d. LOCATION (City, town, or county) Easley	(State) South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Robert A. Pumphrey, Bethesda, Maryland	24a. REC'D BY REGISTRAR 1-21-57	24b. REGISTRAR'S SIGNATURE Benjamin Thompson		

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MAR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03058 CERTIFICATE OF DEATH

03028
2/6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 72 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
Montgomery MARYLAND		Bethesda				a. STATE Maryland b. COUNTY Anne Arundel					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pasadena 02 x 22		d. STREET ADDRESS no street address					
3. NAME OF DECEASED (Type or print)		First Della	Middle Virginia	Last Bailey	4. DATE OF DEATH March 27, 1957	Month March	Day 27	Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1885	9. AGE (In years from birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Richard Roberts		14. MOTHER'S MAIDEN NAME Laura Mathaney									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>											
493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>gratuitous ex. of fibrosis hypercalcaemia</i> (c) <i>metabolic Valvular</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from <u>January 14, 1957</u> to <u>March 27, 1957</u> that I last saw the deceased alive on <u>March 27, 1957</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.							ADDRESS (Street, city or town, state)			DATE SIGNED 3/28/57	
ACTUAL SIGNATURE <i>Thomas Waldmann</i>		M.D.					The Clinical Center National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30/57		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cem.		22d. LOCATION (City, town, or county) Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. Washington</i>		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR APR 3 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompsons					

RECEIVED
FBI BUREAU NEW YORK

APR 3 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03029 Reg. Dist. No. 03059

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Rockville		c. LENGTH OF STAY IN Tb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Swains Lock Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural—Rockville			
3. NAME OF DECEASED (Type or print) JOHN WILLIAM BAKER		First JOHN	Middle WILLIAM		
4. DATE OF DEATH March 22, 1957		Last BAKER	Month March		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1884		
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR 0 months	11. IF UNDER 24 HRS. 27 days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret- Excavator		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	11. BIRTHPLACE (State or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME William Baker			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Nellie Baker-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH sudden					
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/23/57	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Gabriels Cemetery	
22d. LOCATION (City, town, or county) Potomac				(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 3/26/57	
24b. REGISTRAR'S SIGNATURE <i>Laurell Krueger FBI E.C.</i>					
VS. A1SME(S) 5M 9/55					

OFFICIAL EXAMINER'S CERTIFICATE OF CREDIT

BUREAU V.

MAR 27 1957

REGELVÉD

CERTIFICATE OF DEATH

Reg. Dist. No. 214

Item 3-89 G210 4/1/57

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 16 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,503 Broadview Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MADISON	
3. NAME OF DECEASED (Type or print) Robert G. Barker		4. DATE OF DEATH MARCH 18 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 7, 1887/1888	
9. AGE (In years at birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman (retired)		10b. KIND OF BUSINESS OR INDUSTRY C.&O. Railroad	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Barker		14. MOTHER'S MAIDEN NAME Mary Jane Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 719-07-4822	
17. INFORMANT no		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cerebrovascular Accident Silver Spring, MD INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 March 1957 to 18 March 1957, that I last saw the deceased alive on 18 March 1957, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 11602 Georgia Ave DATE SIGNED ACTUAL SIGNATURE Marris Perry PHYSICIAN'S NAME (Type) Marris Perry 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3/20/57 22c. NAME OF CEMETERY OR CREMATORIUM BARKER CEMETERY 22d. LOCATION (City, town, or county) (State) ASHFORD, BOONE COUNTY, W. VA.			
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey, SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/20/57	
24b. REGISTRAR'S SIGNATURE Frances Boller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MICHIGAN - BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03031

03061

CERTIFICATE OF DEATH

Reg. Dist. No. 211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia.		d. STREET ADDRESS R.F.D. Monrovia	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Altie E. Beall		First	Middle
		Last	
4. DATE OF DEATH March 15		Month	Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		8. DATE OF BIRTH Nov. 30. 1876	9. AGE (In years last birthday) 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Lewisdale, Md.
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. King		14. MOTHER'S MAIDEN NAME Mary B. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs T. Deets Day, Monrovia, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs?	
Arteriosclerotic Heart Disease			
DUE TO Generalized Arteriosclerosis.		15 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b)			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from 1935, 19, to 19, that I last saw the deceased alive on March 14, 1957, and that death occurred at 6:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Druid Theatre Building, 3/15/57	
ACTUAL SIGNATURE M. McKendree Boyer, M.D. PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet
		22d. LOCATION (City, town, or county) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		24a. REC'D BY REGISTRAR DATE March 16/57	24b. REGISTRAR'S SIGNATURE M. Ella W. Burdette
		37	

WILHELM V. S.

3 19 1957

GEIWER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)5
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03032
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4609 Harlingka	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James William Berry		First James	Middle William
4. DATE OF DEATH March 3 1957		Last Berry	Month March
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 18, 1956		9. AGE (In years last birthday) yrs. 3 months 14 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Berry		14. MOTHER'S MAIDEN NAME Janet M. Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Father		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brachobacteremia, both lower lobes & right upper lobe INTERVAL BETWEEN ONSET AND DEATH 7 days			
491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) —			
DUE TO (b) —			
DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Cerebral edema. Sarc Tagm. 34.2 gms. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) —	
(State) —			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 3-4-57	
EXAMINER'S NAME (Type) FRANK J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/57	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hebron		22d. LOCATION (City, town, or county) Winchester, Va.	
(State) —			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 3-5-57	
ADDRESS Bethesda Md.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

GEREAU Y. S.

8/9/1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03063

CERTIFICATE OF DEATH

03033

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C.		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3919 Harrison St. NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sophia		First	Middle Elizabeth	Last Brandon	4. DATE OF DEATH March	Month 8	Day 19	Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1871	9. AGE (In years 85 birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Claude Williams		14. MOTHER'S MAIDEN NAME Ann Myrick								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT J. Rapp - 1303 N. Ode Street - Arlin		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH one hour				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalised and (c) Severe Secondary anemia								5 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic carcinoma from breast carcinoma								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3921 Ingeman St. N.W.		20f. (City or town) _____ Washington, D.C.		(County) _____		(State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 3921 Ingeman St. N.W.		DATE SIGNED 3-8-57		
ACTUAL SIGNATURE Stewart Clapp										
PHYSICIAN'S NAME (Type) Stewart Clapp										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Fort Leavenworth		22d. LOCATION (City, town, or county) Belvoir Rd. Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Cheng Chao Funeral Home, 5103 Mac. Ave. NW		ADDRESS H.D. - 11-57		24a. REC'D BY REGISTRAR 11-57		24b. REGISTRAR'S SIGNATURE Bevins M. Thompson				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BULGARIA V. S

LEGEVAD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03034

Item 1 Film G. 13 1-11-57 e

03061

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY

Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

Silver Spring

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED.
(Type or Print)

First: Frank

(Middle) B

(Last) Bright

5. SEX

6. COLOR OR
FACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):

male

white

white

white

8. DATE OF BIRTH

July 9

9. AGE last birthday. IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

85

9

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10A. USUAL OCCUPATION (Give kind of
work done during most of working life
even if retired)10B. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give W.R. or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST

(A) DUE TO

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

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SHIMADA A. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03035

03065

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE ENGLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Summer		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) London			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5707 Rockmere Drive				d. STREET ADDRESS 77X-7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First ELAINE	Middle Matilda	Last BROOKE		4. DATE OF DEATH Mar. 21,	Month Year 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1884	9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months 3 Days 22 Hours 0 Min.	11. IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) London, England	12. CITIZEN OF WHAT COUNTRY? England
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13. FATHER'S NAME George August Werner vonPirch	14. MOTHER'S MAIDEN NAME Susan Hill	Address Item 1, 1.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT Elaine M. vonTempelhoff

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Extensive arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden
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Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 11 th , 1957, to March 26 th , 1957, that I last saw the deceased alive on March 16 th , 1957, and that death occurred at 9:30 a.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED 3/21/57
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ACTUAL SIGNATURE -G. R. Buschak?	M.D.	09. 2225 Eye St. NW, Wash. D. C.
NAME (Type) G. K.	2025 Eye St., N.W., Washington, D.C.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/23/57	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Prince George, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE 3-28-57	24b. REGISTRAR'S SIGNATURE T. Buschak
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HOSPITAL OR AMBULANCE: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU Y. S.

MAR 26 1957

REG-116

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03036

03065

CERTIFICATE OF DEATH

Reg. Dist. No

216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Dist. of Columbia		b. COUNTY Dist. of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2518-Turkland Rd. N.W. 20		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				d. STREET ADDRESS APT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
FRANK FREDERICK				Brown	3-14-57			19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1889-Jan-30	9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Penn. Allegany Co		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME FRANK FREDERICK Brown		14. MOTHER'S MAIDEN NAME Hartill, J.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Ball Brown (Some wife)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma, Head of Pancreas				INTERVAL BETWEEN ONSET AND DEATH 2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Arteriosclerosis, Generalized						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 9 Mar 1957 to 13 Mar 1957, that I last saw the deceased alive on 12 Mar 1957, and that death occurred at 8:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE: <i>J. E. Ash</i>				ADDRESS (Street, city or town, state) M.D. Suburban Hospital, B		DATE SIGNED 14 Mar 57		
PHYSICIAN'S NAME (Type) J. E. ASH								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-57		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln		22d. LOCATION (City, town or county) Baltimore, Md (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home 4812 Ga Avenue Bethesda, Md		ADDRESS West DC		24a. REC'D. BY REGISTRAR 18 1957		REGISTRAR'S SIGNATURE Bessie Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tombstone permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

MAR 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09037

03067

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Incl						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Nolan	Last Brown	4. DATE OF DEATH	Month March	Day 11	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1876	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Attendant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Brown		14. MOTHER'S MAIDEN NAME Amanda N. Anderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-36-9960		17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure INTERVAL BETWEEN ONSET AND DEATH immed.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.1		DUE TO (b) rupture infarct of left ventricle				immed.	
		DUE TO (c) coronary Thrombosis, left main coronary				7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Mar 1 , 1956, to March 11 , 1957, that I last saw the deceased alive on March 10 , 1957, and that death occurred at 3:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Md. DATE SIGNED 3-11-57							
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>	PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-57	22c. NAME OF CEMETERY OR CREMATORIAL Providence	22d. LOCATION (City, town, or county) Glenelg, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.		ADDRESS Ellicott City, Md.	24a. REC'D BY REGISTRAR R. J. R.	24b. REGISTRAR'S SIGNATURE Gertrude Lawless			

BUINSU V. S

2010-02-25
BUINSU

CERTIFICATE OF DEATH

03038-216

Reg. Dist. No.

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1401 Ridge Place, S.E., Anacostia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clinton	Middle Henderson	Last Bryant	4. DATE OF DEATH March 8	Month Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1890	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator		10b. KIND OF BUSINESS OR INDUSTRY Transit Company		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry Bryant				14. MOTHER'S MAIDEN NAME Lula Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-10-5078		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO esophagus INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of the esophagus ONSET AND DEATH (c) 2 radiation pneumonitis. 14 yr. pulmonary fibrosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington	(County) (State) D.C.
21. I certify that I attended the deceased from January 24, 1957 to March 8, 1957 , that I last saw the deceased alive on March 8, 1957 , and that death occurred at 6:07 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE David G. Nathan, M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) DAVID G. NATHAN, M. D. DATE SIGNED 3/9/57					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-12-57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Washington, D.C.	(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee - Wash. D.C.			24a. REC'D BY REGISTRAR 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson	

Y. S. REED

3-5-3 12-5-3 12-5-3
MAY 1942
REED, Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03039
Z/2

03069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson Rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Clara	Middle Elizabeth	Burdette Last BURDETTE		4. DATE OF DEATH	Month March	Day 29	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2 1866		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Thompson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Myrtle Hough		Address Dickerson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 9 intestinal obstruction							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO familial				4 weeks			
		(c) DUE TO Carcinomatous				2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boyd's		20f. (City or town) Boyd's		(County) (State)	
21. I certify that I attended the deceased from 20 Sept. 1948 to March 29 1957, that I last saw the deceased alive on March 27 1957, and that death occurred at 1:30 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) P.O. Box 50, Maryland 3/29/57		DATE SIGNED	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		John G. Fawcett M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 31 57		22c. NAME OF CEMETERY OR CREMATORIAL Boyd's		22d. LOCATION (City, town, or county) Boyd's		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.		24a. REC'D. BY REGISTRAR DATE 4/2/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin per 230.			

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The hospital or attending physician, may be retained by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, attach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELA
BUREAU V. S.

APR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 File No. 0212 3-21-57

03025

CERTIFICATE OF DEATH

Reg. Dist. No.

03025

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Md. Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park		Takoma Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Washington Sanitarium & Hospital		17423 Aspen St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle Colin	Last Campbell
4. DATE OF DEATH	Month 3	Day 12	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-70
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) India		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Archibald Campbell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Washington Sanitarium & Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
Cerebral Hemorrhage Atherosclerosis, Hypertension, General Sys.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac decompensation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1956, to <u>Mar</u> , 1957, that I last saw the deceased alive on <u>Mar 11</u> , 1957, and that death occurred at <u>2:23</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) RAYMOND O. WEST M.D. 7600 Carroll Ave Takoma Park ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) RAYMOND O. WEST			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Weiters, 254 Carroll St NW, D.C.		24a. REC'D BY REGISTRAR DATE 3/13/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE J. Arthur Weiters	

BUREAU V.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03070 CERTIFICATE OF DEATH

Reg. Dist. No. **030412**

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 12 years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805 KING STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING					
3. NAME OF DECEASED (Type or print) DANIEL JOHN CARR		d. STREET ADDRESS 805 KING STREET					
4. DATE OF DEATH MARCH 2	Month	Day	Year 19 57				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 24, 1886				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY PEOPLES DRUG STORES ROCKVILLE, MARYLAND					
11. BIRTHPLACE (State or foreign country) ROCKVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME WILLIAM HENRY CARR		14. MOTHER'S MAIDEN NAME EMMA KLIENDIENST					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 144-88-1444					
17. INFORMANT MRS. MARY B. CARR, same as #2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PHARYNX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9013 Flower Ave.			
(County)		(State)					
21. I certify that I attended the deceased from Feb. , 1948, to Mar. , 1957, that I last saw the deceased alive on 2 Mar., 1957 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) SILVER SPRING, MD.			
				DATE SIGNED 3/3/57			
ACTUAL SIGNATURE L. B. Snow		M.D.					
PHYSICIAN'S NAME (Type) L. B. SNOW							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 6, 1957		22c. NAME OF CEMETERY OR CREMATORIUM ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) ROCKVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Alfred E. Humphrey, SILVER SPRING, MD.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR Frances Teller		24b. REGISTRAR'S SIGNATURE Frances Teller	
				DATE 3/5/57			

BEREAU V. S.

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BEREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03042

03071

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY SILVER SPRING, MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STIRRIBA HOSPITAL				d. STREET ADDRESS 210 GRANVILLE DR. TVF			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First JOHN	Middle	Last CHRISTENSEN	4. DATE OF DEATH MARCH	Month	Day 4 Year 19 57
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15, 1887		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (retired)		10b. KIND OF BUSINESS OR INDUSTRY State Brand Creameries, Inc.		11. BIRTHPLACE (State or foreign country) DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JENS CHRISTENSEN				14. MOTHER'S M AIDEN NAME CHRISTIANA LARSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Oda J. Christensen, 210 Granville Drive		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 DUE TO Leukemia, lymphatic Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 to 4 March 1957, that I last saw the deceased alive on 3 March 1957, and that death occurred at 11:11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE WILLIAM E. AUD M.D. ADDRESS (Street, city or town, state) WILLIAM D. AUD DATE SIGNED PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/6/57		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey, SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 8-6-57		24b. REGISTRAR'S SIGNATURE Bernie M. Homfray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
03072 CERTIFICATE OF DEATH					03043 Reg. Dist. No. 276								
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if inst. not on, Residence before admission) a. STATE West Virginia		b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 258 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beckley									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md.				d. STREET ADDRESS None- General Delivery									
3. NAME OF DECEASED (Type or print) First Otho Middle Olders Last Colvin				4. DATE OF DEATH March 26 1957									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 January 1883		9. AGE (In years (lost birthday) yrs.) 74		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Colvin					14. MOTHER'S MAIDEN NAME Amanda Ross								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Single lung cancer I was suffering from		19. INTERVAL BETWEEN ONSET AND DEATH 5 mos.											
150X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Carcinoma, post irradiation (c) Autosomal dominant		18 mos.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Riley County, W. Virginia		(County) Riley County		(State) W. Virginia			
21. I certify that I attended the deceased from 11 July 1956 to 26 March 1957 , that I last saw the deceased alive on 26 March 1957 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.													
ACTUAL SIGNATURE <i>Peter D. Olch, M.D.</i>		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 3/26/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3-27-57		22b. DATE THEREOF 3-27-57		22c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial Cem.		22d. LOCATION (City, town, or county) Riley County, W. Virginia		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-28-57		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>							

BUREAU U. S.

APR 1 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03044

03073

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-		d. STREET ADDRESS 511 4th Street, S.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Belisario		First	Middle (nnn)	Lost	4. DATE OF DEATH March	Month	Day 6	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 20 Oct. 1887	9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? U.S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Spain				
13. FATHER'S NAME Belisario Contreras		14. MOTHER'S MAIDEN NAME Berardi Ramos						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1-20-09 to 9-1-40		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Official Navy Records)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.				19. INTERVAL BETWEEN ONSET AND DEATH Cerevia				
(b) DUE TO cause (a), stating the under- lying cause first.				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diverticulitis of colon		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19.57, and that death occurred at 01:00AM, from the causes and on the date stated above.						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 27 Feb., 1957, to 6 March, 1957, that I last saw the deceased alive on 6 March, 1957, and that death occurred at 01:00AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 6 Mar. 57 DATE SIGNED								
ACTUAL SIGNATURE W.C.E. Pfiscner		22. PHYSICIAN'S NAME (Type) W.C.E. Pfiscner, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John Chambers Chambers Funeral Home, 517 11th St., S.E.		ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR DATE 3-6-57		24b. REGISTRAR'S SIGNATURE Frank G. Mullally		

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V. 4

MAR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03045

03074

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1 PLACE OF DEATH
a COUNTY

Montgomery

MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda 14, Md.

c LENGTH OF STAY IN lb

22 days

d NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived if institutional or Residence before admission)
a STATE

District of Columbia

b COUNTY

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington 14

d STREET ADDRESS

1343 Montague Street, N. W.

e IS RESIDENCE
ON A FARM?YES NO 3 NAME OF
DECEASED
(Type or print)First
HermeneMiddle
LeonLast
Cock4. DATE
OF
DEATHMonth
MarchDay
3, 19 57

5 SEX

6 COLOR OR RACE

7 MARRIED NEVER MARRIED

8 DATE OF BIRTH

9. AGE (in years
at birthday)

34 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS

Male

White

WIDOWED DIVORCED

Months

Days

Hours

Min

10a USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Salesman

10b KIND OF BUSINESS OR INDUSTRY

Automobile

11 BIRTHPLACE (State or foreign country)

Maine

12 CITIZEN OF WHAT COUNTRY?

U. S. A.

13 FATHER'S NAME

John T. Cock

14 MOTHER'S MAIDEN NAME

Albina Bowley

15 WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes or no or unknown) (If yes, give war or date of service)

Yes

Korean

16 SOCIAL SECURITY NO

005-16-4752

17 INFORMANT

The Medical Record

address

The Clinical Center, Bethesda 14, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

190X

DUE TO

MALIGNANT MELANOMA WITH

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b) METASTASES TO LIVER AND ADRENALS 13 MOS

(c)

MEDICAL CERTIFICATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)

RETROPERITONEAL HEMORRHAGE

19. WAS AUTOPSY
PERFORMED?
YES NO 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d INJURY OCCURRED
While at work Not while at work

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town)

(County)

(State)

21. I certify that I attended the deceased from February 9, 1957, to March 3, 1957, that I last saw the deceased
alive on March 3, 1957, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Samuel Charache, M. D.

The Clinical Center

National Institutes of Health
Bethesda 14, Maryland

3/4/57

22a BURIAL, CREMATION, REMOVAL (Specify)

BURIAL Transit 3/4/57

22b DATE THEREOF

Calvary Cemetery

22d LOCATION (City, town, or county)

Portland, Maine

(State)

23 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Robert A. Pumphrey

Bethesda, Maryland

24a REC'D BY REGISTRAR

DATE 3-5-57

24b REGISTRAR'S SIGNATURE

Bevrie W. Thorpe

SUREAU V. S.

MAR 7 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03026

CERTIFICATE OF DEATH

03046
23

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>—</i>		b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 hours 4 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>—</i>		d. STREET ADDRESS <i>—</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Infant</i>	Middle <i>Boy</i>	Last <i>Craver</i>	4. DATE OF DEATH <i>March 26</i>	Month <i>March</i>	Day <i>26</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1957</i>		9. AGE (In years lost birthday) yrs. <i>—</i>	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS. Days <i>4</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>	
13. FATHER'S NAME <i>Fred M^o Gill Craver</i>		14. MOTHER'S MAIDEN NAME <i>Joan Marie Eaton</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO <i>Ateteritis.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		(b) DUE TO <i>Prerenal</i>		(c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24h.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>—</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/25/57</i> to <i>3/26/57</i> , that I last saw the deceased alive on <i>3/26/57</i> , and that death occurred at <i>1:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Raymond Chinn</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Raymond Chinn, M.D.</i> DATE SIGNED <i>925 Reservoir Drive 3/26/57</i> <i>Silver Spring, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>3-28-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington San. & Hospital</i>		22d. LOCATION (City, town, or county) <i>Takoma Park, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. March</i>		ADDRESS <i>Washington Sanitarium & Hosp.</i>		24a. REC'D BY REGISTRAR <i>3/24/57</i>		24b. REGISTRAR'S SIGNATURE <i>Robert A. March</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

APR 2 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03047

03075

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 45 days		2. USUAL RESIDENCE (Where deceased lived) <input checked="" type="checkbox"/> INSTITUTION <input type="checkbox"/> Residence before admission a. STATE Tennessee		b. COUNTY Sullivan	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsport		d. STREET ADDRESS 1812 B Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle William	Lost Crawford	4. DATE OF DEATH March 13 1957	Month Year	Month Year	Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1936	9. AGE (In years last birthday) 20 yrs	F. UNDER 1 YEAR Months 7	IF UNDER 24 HRS Days 12	Hours Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ace Crawford			14. MOTHER'S MAIDEN NAME Mabel Gaylon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754.4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO Acute Heart Failure									INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post operative Closure of IASD									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Kingsport		(County) Tennessee	(State) 18
21. I certify that I attended the deceased from January 27, 1957 , to March 13, 1957 , that I last saw the deceased alive on March 13, 1957 , and that death occurred at 2:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center									
ACTUAL SIGNATURE <i>Edward H. Sharp</i>	M.D.	DATE SIGNED 3/13/57							
PHYSICIAN'S NAME (Type) Edward H. Sharp, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 3/13/57	22c. NAME OF CEMETERY OR CREMATORIAL East Lawn Memorial		22d. LOCATION (City, town, or county) Kingsport, Tennessee		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS 7557 Wisc. Ave. Beth. Md.	24a. REC'D BY REGISTRAR 3-14-57		24b. REGISTRAR'S SIGNATURE Bruce M. Thompson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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RECEIVED

MAR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03048

03076

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Rural		c. LENGTH OF STAY IN 1b 69 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
3. NAME OF DECEASED (Type or print) Wallace		First Montgomery	Middle Crown
4. DATE OF DEATH Mar 9 1957		Month Mar	Day 9
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb 18 1880		9. AGE (In years from birthday) 75 yrs.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME James H. Crown		14. MOTHER'S MAIDEN NAME Sarah V. Case	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Forest F. Crown, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inevitable cerebral hemorrhage</i> - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arteriosclerosis, hypertension</i> - DUE TO (c) <i>Epileptic focus attacks</i>		INTERVAL BETWEEN ONSET AND DEATH few hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>March 9, 1957</u> that I last saw the deceased alive on <u>Feb 15, 1957</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Gaithersburg, Md.	
ACTUAL SIGNATURE <i>W. A. Linthicum</i>		DATE SIGN M.D. 26 N. Summit Ave. Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Wm A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-57	
22c. NAME OF CEMETERY OR CREMATORIAL Rockville Union		22d. LOCATION (City, town, or county) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR DATE 3-11-57		24b. REGISTRAR'S SIGNATURE <i>Alfred G. Conner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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RECEIVED
BUREAU V. S.

MAR 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03077

CERTIFICATE OF DEATH

03049

216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 112 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rosie	Middle Lee	Last Davis
4. DATE OF DEATH	Month March	Day 11	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1914
9. AGE (In years to nearest birthday) yrs 42	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Waitress Work	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Nicks		14. MOTHER'S MAIDEN NAME Ida Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 577-30-8907	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cerebral vascular accident			
b) Methotrexate (Chemotherapy) and bilateral hydrocephalus. Original site—Cervix			
c) and bilateral hydrocephalus. Original site—Cervix			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 19, 1956 to March 11, 1957 , that I last saw the deceased alive on March 11, 1957 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE <i>Thomas Waldman</i>		DATE SIGNED 3/11/57	
PHYSICIAN'S NAME (Type) Thomas Waldman, M. D.		MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-15-57	
22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE For J. L. Funeral Home		ADDRESS 1213 4th Street, N.W., D.C.	
24. REGISTRAR'S SIGNATURE Reuben Thompson		DATE MAR 18 1957	

RECEIVED
FBI BUREAU V. S.

MAR 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03027

CERTIFICATE OF DEATH

03050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Maryland</i>		c. LENGTH OF STAY IN 1b <i>11 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium and Hospital 8504 Flushing Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Maryland</i>	
d. STREET ADDRESS <i>8504 Flushing Ave.</i>		f. STREET ADDRESS <i>8504 Flushing Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>John PAUL DECKER</i>		4. DATE OF DEATH <i>3/15</i>	Month Year <i>1957</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/14/94</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shipping clerk</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elza Decker</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Hart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>578-24-9474</i>	
17. INFORMANT <i>Patient's chart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Lower Pneumonia (Rt Mid-Lobe)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- <i>(b)</i> cause (a), stating the under- <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension Hypertrophy of Heart with Marked Coronary Sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/29</i> , 19 <i>57</i> , to <i>3/15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/15</i> , 19 <i>57</i> , and that death occurred at <i>4:05 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dean H. Harding</i>		ADDRESS (Street, city or town, state) <i>113 Carroll St NW, Wash 12 DC 3/15/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>3/8/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael E. L. Thompson</i>		ADDRESS <i>3125 Spring St NW, Washington, DC 20007</i>	
24a. REC'D BY REGISTRAR DATE <i>3/8/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. W. L. H.</i>	

BUREAU V. S.

MAR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03028 CERTIFICATE OF DEATH

Reg. Dist. Q30513

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 hours min.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47x-3</i>		d. STREET ADDRESS <i>2029 Conn. Ave., N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louis Malvern Denit</i>		First	Middle	Last	4. DATE OF DEATH <i>3 - 7 - 1957</i>	Month	Day	Year	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3-26-1896</i>	9. AGE (In years less birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Henry Denit</i>		14. MOTHER'S MAIDEN NAME <i>Hattie MacPherson</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WW #1</i>		17. INFORMANT <i>Washington Sanitarium & Hospital</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary infarction</i>		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). <i>General arteriosclerosis</i>		DUE TO							
DUE TO <i>Diabetes</i>		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Diabetes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>2000 P St NW #415</i>		(County) <i>D.C.</i>	(State) <i>D.C.</i>
21. I certify that I attended the deceased from <i>10/7/53</i> , 19, to <i>3/7/57</i> , 19, that I last saw the deceased alive on <i>3/7/57</i> , 19, and that death occurred at <i>2:30 PM</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Allen Lee</i>		ADDRESS (Street, city or town, state) <i>2000 P St NW #415</i>							DATE SIGNED <i>3/11/57</i>
PHYSICIAN'S NAME (Type) <i>ALLEN LEE</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i>							
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22f. DATE THEREOF <i>3/11/57</i>		22g. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L CEMETERY</i>		(State) <i>VA</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Murphy</i>		ADDRESS <i>8434 Gaithers</i>		24a. REC'D BY REGISTRAR DATE <i>3/11/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. M. Rodd</i>			

BUILAU V. S

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1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03078

CERTIFICATE OF DEATH

030524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 12,814 HOLDRIDGE ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,814 HOLDRIDGE ROAD				d. STREET ADDRESS 12,814 HOLDRIDGE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EUGENE	Middle (nmi)	Last DICKENS	4. DATE OF DEATH MARCH 10	Month 19	Day 57	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1881	9. AGE (In years lost 75 birthdays) 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER AT SOLDIERS' HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD S. DICKENS		14. MOTHER'S MAIDEN NAME MARY OWENS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. 577-34-9751		17. INFORMANT MRS. EDITH ELLEN DICKENS, Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cirrhotic congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 day			
4/20/1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Coronary heart disease		2 years			
		DUE TO (c) Generalized arteriosclerosis		5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1950, to <u>March 10, 1957</u> that I last saw the deceased alive on <u>March 6, 1957</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Samuel M Bageant</u> M.D. 5600 N.H. Ave Wash. D.C.		ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type)		<u>SAMUEL M BAGEANT</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 13, 1957		22c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEORGE'S CO., MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/13/57		24b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

MAR 19 1957

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03079

CERTIFICATE OF DEATH

03053

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		d. STREET ADDRESS <i>2417 East West Hwy.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>NORA</i>		First	Middle	Last	4. DATE OF DEATH <i>Doherty</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 16, 1873</i>	9. AGE (In years last birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS Days <i>4</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Naturalized</i>			
13. FATHER'S NAME <i>MARTIN Fitzpatrick</i>		14. MOTHER'S MAIDEN NAME <i>Bridgett</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>(daughter) Marion McCarthy</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis & Encephalitis, right</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4325 49th St. N.W., Wash. D.C.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 7, 1957</i> to <i>March 22, 1957</i> that I last saw the deceased alive on <i>March 20, 1957</i> , and that death occurred at <i>1:57 P.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>4325 - 49th St. N.W., Wash. D.C.</i>									
DATE SIGNED <i>3/20/57</i>									
ACTUAL SIGNATURE <i>Clifton R. Gruver</i>		M.D. <i>4325 49th St. N.W., Wash. D.C. 3/20/57</i>							
PHYSICIAN'S NAME (Type) <i>Clifton R. Gruver, M.D.</i>		4325 - 49th St. N.W., Wash. D.C.		3/20/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-transit</i>		22b. DATE THEREOF <i>3/22/1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Denis</i>		22d. LOCATION (City, town, or county) <i>Delaware County Pennsylvania</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</i>		ADDRESS <i>7557 Wis. Ave. Bethesda, Md. 20813-25-57</i>		24a. REC'D BY REGISTRAR <i>Bevrie W. Thompson</i>		24b. REGISTRAR'S SIGNATURE <i>Bevrie W. Thompson</i>			

BUREAU Y. S

103 1937

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03080

CERTIFICATE OF DEATH

03054

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>349 Ds.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmer San.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 7, D.C.</i>					
3. NAME OF DECEASED (Type or print) <i>Ida</i>		First <i>Sullivan</i>	Middle <i>Dolan</i>				
4. DATE OF DEATH <i>March 3 1957</i>	Month <i>March</i>	Day <i>3</i>	Year <i>1957</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-7-1874</i>				
9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>				
13. FATHER'S NAME <i>Dennis Sullivan</i>	14. MOTHER'S MARRIED NAME <i>Teresa B. O'Donoghue</i>	15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			16. KIND OF BUSINESS OR INDUSTRY	17. BIRTHPLACE (State or foreign country) <i>Georgetown, D.C.</i>	18. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	20. SOCIAL SECURITY NO	21. INFORMANT <i>John J. Dolan</i>	22. ADDRESS <i>1323 30th Street NW Washington, DC</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <i>(b)</i> <i>Aut. in. Silverte. 1957</i> <i>(c)</i> <i>Aut. in. Silverte. 1957</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1957</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>3066 Que Street NW</i>	(County) <i>Washington, DC</i>	(State) <i>DC</i>		
21. I certify that I attended the deceased from <i>Oct 1, 1971</i> to <i>Feb 5, 1957</i> that I last saw the deceased alive on <i>Feb 5, 1957</i> , and that death occurred at <i>3066 Que Street NW</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3066 Que Street NW, Washington, DC</i>							
ACTUAL SIGNATURE <i>E. Stuart Lyddane</i>		DATE SIGNED <i>1957</i>					
PHYSICIAN'S NAME (Type) <i>E. STUART LYDDANE, MD</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					
22b. DATE THEREOF <i>3/7/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, DC</i>			
22. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Guerrieri Sons</i>		ADDRESS <i>1752 Pa. Ave. NW, Washington, DC</i>		24a. REC'D BY REGISTRAR DATE <i>3-6-57</i>			
				24b. REGISTRAR'S SIGNATURE <i>Bruce M. Thompson</i>			

BUREAU Y.
RECEIVED

MAR 8 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03055

03081

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4711 Essex Avenue		d. STREET ADDRESS 4711 Essex Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Louise	Middle M.	Last DONCH
4. DATE OF DEATH	Month March	Day 25	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 1, 1865
9. AGE (In years lost birthday) 91 yrs		10. IF UNDER 1 YEAR Months 11 Days 24	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Music teacher		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Donch		14. MOTHER'S MAIDEN NAME Elise Brand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lillian A. McNish-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis, general		20 yrs 20 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington (County) D. C. (State)	
21. I certify that I attended the deceased from Oct. 1950 to 25 Mar. 1957 , that I last saw the deceased alive on 25 March 1957 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5315 - 16th St. N. W. Wash. D. C. DATE SIGNED 3/25/57			
ACTUAL SIGNATURE Francis T. Coleman		M.D. Francis T. Coleman	
PHYSICIAN'S NAME (Type) Francis T. Coleman, M. D.		5315 - 16th St. N. W. Wash. D. C. 3/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/57	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington (State) D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE - 28-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y-4

PPR

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03056

03029

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> D.C. 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANATORIUM</u>		d. STREET ADDRESS <u>720 - PEABODY ST NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>Jacob</u>	Middle <u>Dreifus</u>	4. DATE OF DEATH Month <u>3</u> - Day <u>19</u> - Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2nd 1897</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired, businessman.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Germany</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Isaac Dreifus.</u>	14. MOTHER'S MAIDEN NAME <u>EVA MAIER.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mr. Julius Dreifus, patient</u>	Address <u>same as</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate gland</u> DUE TO <u>metastasis into the pelvic area</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Gluerized cactus pins and malnutrition</u> (c) —					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>3-15</u> , 1957, to <u>3-19</u> , 1957, that I last saw the deceased alive on <u>3-19</u> , 1957, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 10401 NEW STAMPSHIRE AVE</u> DATE SIGNED <u>VERONICA TROOST</u>					
ACTUAL SIGNATURE <u>VERONICA TROOST</u>		M.D. 10401 NEW STAMPSHIRE AVE SILVER SPRING, M.D.			
PHYSICIAN'S NAME (Type) <u>VERONICA TROOST M.D.</u>					
22a. BURIAL/CREMATION, REMOVAL (Specify) <u>3-20-1957</u>	22b. DATE THEREOF <u>3-20-1957</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>M. LEBANON</u>	22d. LOCATION (City, town, or county) <u>HYATTSVILLE M.D.</u>	(State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Derganeky & SONS</u>		ADDRESS <u>3501-14th NW</u>	24a. REC'D BY REGISTRAR <u>3/21/57</u>	24b. REGISTRAR'S SIGNATURE <u>John W. Roth</u>	
VS A15 (4) 1 M 9/55		DATE			

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1937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03082

CERTIFICATE OF DEATH

Reg. Dist. No. *03057*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. This page should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5032 Bradley Blvd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5032 Bradley Blvd. Apt. 7</i>				d. STREET ADDRESS <i>5032 Bradley Blvd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Paul</i>		First	Middle	Lost	4. DATE OF DEATH <i>March 24 1957</i>	Month	Day	Year	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 20 1917</i>	9. AGE (In years last birthday) <i>40 yrs</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>4</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>broker</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Peter A. Drury</i>		14. MOTHER'S MAIDEN NAME <i>Jean Walsh</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT Loretta O. Drury 5032 Bradley Blvd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>		DUE TO <i>Central Respiratory Failure</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Multiple Sclerosis (C.M.S.)</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 8016 Georgetown Rd. Beth 14, Md.</i>		20f. (City or town) <i>Georgetown</i>		(County) <i>Bethesda</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Dec. 1955</i> to <i>March 1957</i> , that I last saw the deceased alive on <i>March 23, 1957</i> , and that death occurred at <i>545A M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>8016 Georgetown Rd. Bethesda, Md.</i>		DATE SIGNED <i>3/26/57</i>			
ACTUAL SIGNATURE <i>Leo I. Donovan</i>									
PHYSICIAN'S NAME (Type) <i>Leo I. Donovan, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/27/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>		22d. LOCATION (City, town, or county) <i>Silver Spring, Montg. Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>3-28-57</i>		24b. REGISTRAR'S SIGNATURE <i>Bevill M. Thompson</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03058

03083

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 151 Days		b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster		d. STREET ADDRESS 620 North Queen Street		
3. NAME OF DECEASED (Type or print) Oscar		First Oscar	Middle Eugene	Last Duffy	4. DATE OF DEATH Month March Day 4th, Year 19 57	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 22nd, 1885	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Rug making		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Duffy		14. MOTHER'S MAIDEN NAME Rebecca Fisher				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-09-1778		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 160X		DUE TO Brain abscess metastatic cancer from?		INTERVAL BETWEEN ONSET AND DEATH 1 month		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Carcinoma of left maxillary antrum		(c) lyrot				
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 6 a.m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1:05A		20f. (City or town) ADDRESS (Street, city or town, state) The Clinical Center
21. I certify that I attended the deceased from October 4th, 19 56 to March 4th, 19 57 , that I last saw the deceased alive on March 4th, 19 57 , and that death occurred at 1:05A , from the causes and on the date stated above. ACTUAL SIGNATURE R. W. Weiger, M.D.		M.D.		DATE SIGNED 3/4/57		
PHYSICIAN'S NAME (Type) R. W. Weiger, M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 3/7/57		22b. DATE THEREOF 3/7/57		22c. NAME OF CEMETERY OR CREMATORIAL Elden Lutheran		22d. LOCATION (City, town, or county) Lancaster, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR 8-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRY

MAR 3 1957

BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03059
214

03081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WASHINGTON		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RENSINGTON		c. LENGTH OF STAY IN lb 6 mos		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL REST HOME		d. STREET ADDRESS 505-DECATUR ST. NW.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELLIS		First	Middle	Losi	4. DATE OF DEATH DUKE	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN-7-1874	9. AGE (In years lost birthday) 98 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY SOFT DRINK		11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ABRAHAM DUKE		14. MOTHER'S MAIDEN NAME SOPHIE		Address S. 15th St. 1500					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT HERBERT DUKE mrs. - Ross Kd		INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conges in heart failure		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH yes			
(c) Senility						INTERVAL BETWEEN ONSET AND DEATH yes			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma lg. bowel - heart 1954 - WOUNDS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1954 - WOUNDS							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Kensington Md.		20f. (City or town) (County) Kensington Md.		(State) Md.	
21. I certify that I attended the deceased from 8/2/56 , 19 56 , to 3/31/57 , 19 57 , that I last saw the deceased alive on 3/30/57 , 19 57 , and that death occurred at 505 Decatur St. NW , from the causes and on the date stated above. ACTUAL SIGNATURE Sam Allen						ADDRESS (Street, city or town, state) Kensington Md.			DATE SIGNED 3/31/57
PHYSICIAN'S NAME (Type) Sam Allen		M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF APR-2-1957		22c. NAME OF CEMETERY OR CREMATORIAL NATL. MEM. PARK		22d. LOCATION (City, town, or county) FALLS CHURCH VA.		(State) VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Allen		ADDRESS 4217 25th St. NW		24a. REC'D BY REGISTRAR 4/4/57		24b. REGISTRAR'S SIGNATURE Frances Miller			
VS A15 (4) 1SM 9/55									

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.
 VS AISC 155 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03060

CERTIFICATE OF DEATH

03085

Reg. Dist. No. 216

1. PLACE OF DEATH

COUNTY

CITY (If outside corporate limits, write RURAL
OR
TOWN
give nearest town)

MARYLAND

LENGTH OF STAY
(in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

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BUREAU V. A

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086 CERTIFICATE OF DEATH

Reg. Dist. No. 296

03061
296

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 185 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x		d. STREET ADDRESS 3101 Massachusetts Avenue, N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Wentzel	Middle During	Last Du Plessis	4. DATE OF DEATH March 31, 1957	Month March	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 26, 1935	9. AGE (In years last birthday) 21	10. IF UNDER 1 YEAR Months 21	11. IF UNDER 24 HRS Days Hours	12. IF UNDER 24 HRS Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? South Africa	
13. FATHER'S NAME Wentzel C. Du Plessis				14. MOTHER'S MAIDEN NAME Marie During			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
No		None					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>increased intracranial pressure</i> DUE TO - <input checked="" type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>hemorrhage</i> DUE TO (c) <i>unknown</i>							
INTERVAL BETWEEN ONSET AND DEATH 10 days							
36 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Epilepsy - post operative</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince Georges Co., Md. (County) Maryland (State)	
21. I certify that I attended the deceased from September 27, 1956 , to March 31, 1957 , that I last saw the deceased alive on March 31, 1957 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE <i>Robert Gordon Long, M.D.</i> DATE SIGNED 3/31/57							
PHYSICIAN'S NAME (Type) Robert Gordon Long, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) Prince Georges Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, D.C. ADDRESS DATE APR 2 1957 REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>							

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03062

03055

CERTIFICATE OF DEATH

Reg. Dist. No.

219

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE		Maryland			
Montgomery				b. COUNTY		Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Rockville, Md.		6 weeks		Bethesda		16120-Temple Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Congressional Manor Sanitarium				16120-Temple Street					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Sally		Amenda	Edgar		March	18		1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		W		1/21/1885	72 yrs	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Practical Nurse				Georgia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Benjamin Bray		MacMillian							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		577-44-7612A		Mrs. Joanne Metzner		6120 Temple St Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebro-vascular accident 2nd				3 months			
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO							
		(b) arterio sclerosis				years			
		(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour a. p.		19	While Not while at work <input type="checkbox"/>						
p. m.									
21. I certify that I attended the deceased from Jan 13, 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 9: A M, from the causes and on the date stated above									
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)							
Allen J. O'Neill		M.D. 8601 Old Georgetown Rd, Bethesda, Md.							
PHYSICIAN'S NAME (Type)		DATE SIGNED							
Allen J. O'Neill		March 18, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial		3/21/57		Fort Lincoln Cemetery		Belair Manor, Md., Pr. Geo.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		Mt. Laurel		REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Halleys Funeral Home		3200-R. Ave.				DATE 3/1/1957		Laurel Kreytop	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03063

Reg. Dist. No.

214

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tomb permit. File pages 1 and 2 with the registrar prior to burial-removal.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburb Hospital 8601 Old Georgetown Rd. 4722-47th N.W.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47th</i>	
3. NAME OF DECEASED (Type or print) <i>Emily Eberhardt</i>		d. STREET ADDRESS <i>4722-47th N.W.</i>	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH <i>March 4 1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Feb 13 1867</i>		9. AGE (in years last birthday) <i>90 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Schott, Joseph</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Schott, Walter 4722 47th St. N.C.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Acute congestive heart failure & stroke</i> INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> 903.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture of left hip</i> 4 days (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Fell on floor of her home</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>2:30 p.m. 3-2 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Washington</i>		(County) <i>D.C.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>3-6-57</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/9/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional Cemetery</i>		22d. LOCATION (City, town or county) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Chan Funeral Home</i>		ADDRESS <i>5103 3rd St. NW</i>	
24a. REC'D BY REGISTRAR <i>3/10/57</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	
DATE <i>3-11-57</i>			

BUERA V. S

MAR 19 1966
MICHIGAN STATE LIBRARIES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03088

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03064

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). o STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		c. LENGTH OF STAY IN 1b 39 hr. 39 min.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 4311 Overlook Ave., S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Ruth	Middle Elaine	R Last ELDREDGE	4. DATE OF DEATH March	Month 26	Day 1957	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 24 March 1957	9. AGE (in years last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME Thomas G. Eldredge	14. MOTHER'S MAIDEN NAME Diane Gertrude Robins	15. ADDRESS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT (Father) Thomas G. Eldredge (Same As 12)
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH INDEFINITE
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART BLOCK, CONGENITAL	
754.4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO	
(c) DUE TO	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
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20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from alive on 26 March 1957, and that death occurred at 3:10 P.M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <i>Daniel Shuntar</i>	M.D. U.S. Naval Hospital, Bethesda, Md. 3-27-57
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PHYSICIAN'S NAME (Type) Daniel Shuntar, LT MC, USN	U.S. Naval Hospital, Bethesda, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	22d. LOCATION (City, town or county), (State) Arlington, Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.	ADDRESS 2051 52XV3	24a. REC'D BY REGISTRAR DATE 3-27-57	24b. REGISTRAR'S SIGNATURE <i>Frances E. Garsley</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03089 CERTIFICATE OF DEATH

04217

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3507 HARRELL STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 3507 HARRELL STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FREDERICK	Middle CHARLES	Last EVANS
4. DATE OF DEATH	Month MARCH	Day 30	Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/72
9. AGE (in years last birthday) 84	10. IF UNDER 1 YEAR Months Years	11. IF UNDER 24 HRS Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) UTAH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK H. EVANS		14. MOTHER'S MAIDEN NAME EMMA RAYMOND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth E. Yashko, 3507 Harrett St.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastroesophageal reflux disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 23, 1957</u> to <u>March 30, 1957</u> , that I last saw the deceased alive on <u>March 29, 1957</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 10620 Georgia Ave., Silver Spring, MD 20910	
ACTUAL SIGNATURE Michael P. Dobridge		DATE SIGNED 3/30/57	
PHYSICIAN'S NAME (Type) Mrs. Mae R. Dobridge			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 3/31/57		22b. DATE THEREOF LOGAN CITY CEMETERY	
22c. LOCATION (City, town, or county) LOGAN, UTAH		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold E. Humphrey		24a. REC'D BY REGISTRAR DATE 4/8/57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Frances Potter	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transmittal permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRATION
NUMBER 44

APR 10 1952

TO DEATH: This certificate should be executed within 21 days after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03065
214

Reg. Dist. No.

03090		2		00		2		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23	
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE																																																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b																																																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FLOWER DELICATESSEN, 8707 FLOWER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																			
3. NAME OF DECEASED (Type or print) DAVID FEINSTEIN		4. DATE OF DEATH MARCH 28 1957																																																			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 20, 1895	9. AGE (in years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.																																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.																																															
13. FATHER'S NAME ELIAS FEINSTEIN		14. MOTHER'S MAIDEN NAME PESYAH GOLINOFSKY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1		17. INFORMANT Mrs. Ida Feinstein, 8230 14th Ave., Hyattsville, Md.		Address																																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH Sudden																																																	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)																																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																															
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																																													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCHE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/28/57																																															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF MAR. 29, 1957		22c. NAME OF CEMETERY OR CREMATORIUM BENAI ISRAEL CEMETERY		22d. LOCATION (City, town, or county) OXEN HILL MD.																																															
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS 3501-14 ST. NW		ADDRESS		24a. REC'D BY REGISTRAR DATE 3 1957		24b. REGISTRAR'S SIGNATURE Frances Potter																																															

BUREAU V. S.

APR 3 0 1968

MECE V. L.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03066

03091

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Montgomery Co. MARYLAND		2480 - 16th St. N.W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		b. COUNTY	
Bethesda, Md.		Washington, D.C. 411	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
5921 Grosvenor Lane		2480-16th St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Marion		F.	Finucane
4. DATE OF DEATH		Month	Day
May 29		1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 22 1897
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR OR UNDER 24 HRS Months Days Hours Min.	
57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Secretary		U.S. Gov.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Wash. D.C.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Daniel Francis Finucane		Norah Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address	
UNKNOWN		Dr. Finucane - brother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4 HRS.	
Cerebral Hemorrhage			
301 X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) ESSENTIAL HYPERTENSION	
{		5 years	
DUE TO			
(c) ARTERIOSCLEROSIS		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
NOV 1 1956		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from		Jan 1955 to March 29, 1957, that I last saw the deceased alive on March 29, 1957, and that death occurred at 11:20 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
SAMUEL DESSOFF		M.D. 1302-188th. W. Wash. D. C.	
PHYSICIAN'S (Name/Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF	
Burial April 1, 1957		22c. NAME OF CEMETERY OR CREMATORIUM	
22d. LOCATION (City, town, or county) (State)		Mt. Olivet	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR	
N.W. Chambers Co.		24b. REGISTRAR'S SIGNATURE	
3072-H-N.W.		DATE 1957	
Bea Thompson			

BUREAU X

APR 1 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03092 CERTIFICATE OF DEATH

03067

Reg. Dist. No. 216

1 PLACE OF DEATH • COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE District of Columbia			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 138 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d NAME OF HOSPITAL (If not in hospito, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d STREET ADDRESS 713 "D" Street, S. E.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Myrtle	Middle Lucille	Last Foley	4. DATE OF DEATH	Month March	Day 26,	Year 19 57
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1898	9. AGE (In years lost yrs)	F UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Andrew J. Wilson				14. MOTHER'S MAIDEN NAME Allie White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) <i>Bilateral bronchopneumonia</i> DUE TO c) <i>Carcinoma of breast c metastases to liver, adrenals, bone, dura, and lung</i>				INTERVAL BETWEEN ONSET AND DEATH 2-3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 8, 1956, to March 26, 1957, that I last saw the deceased alive on March 26, 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Samuel Charache, M.D.</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington Vn. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>El Funeral Home</i>		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE 3-28-57		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

BUREAU Y. S.

APR 1 1957

REGELVET

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
03093 CERTIFICATE OF DEATH

03068

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Arlington	
3. NAME OF DECEASED (Type or print) James Monroe FROST		d. STREET ADDRESS 3817 South 9th Street,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 25 Oct. 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S.M.C. (Retired)	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Frost		14. MOTHER'S MAIDEN NAME Ann Gerhardt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or date of service) Yes 1921 to 1932		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Sister) Mildred E. Abel (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic fibro-cystic lung disease with emphysema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 February, 1957, to 1 March, 1957, that I last saw the deceased alive on 1 March, 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harold I. Passes, M.D. U.S. Naval Hospital, Bethesda, Maryland			
PHYSICIAN'S NAME (Type) Harold I. Passes, LT, MC, USNR		U.S. Naval Hospital, Bethesda, Md. 3-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-57	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home		ADDRESS 2847 Wilson Blvd. Arl. Va.	
		24a. REC'D BY REGISTRAR DATE 3-2-57	
		24b. REGISTRAR'S SIGNATURE James E. Passes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8. V. LUNAU

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03030 CERTIFICATE OF DEATH

Reg. Dist. No. 223

03069

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		d. STREET ADDRESS 923 NORTHAMPTON DRIVE	
3. NAME OF DECEASED (Type or print) CARLOS		First LEE	Middle GARTRELL
Last		4. DATE OF DEATH MARCH 23	Month Year Day Year 19 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 27, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.	
11. BIRTHPLACE (State or foreign country) SILVER SPRING, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEPHEN GARTRELL		14. MOTHER'S MAIDEN NAME HELEN CHANEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW # 11 yes	
17. INFORMANT Mrs. Eugenia R. Gartrell, 923 Northampton Dr.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 15.6		INTERVAL BETWEEN ONSET AND DEATH 3 months	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 18, 1956, to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 6 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE JOHN J. CURRY M.D.		ADDRESS (Street, city or town, state) 10620 Georgia Ave. 3/23/57 Silver Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/25/57	
22c. NAME OF CEMETERY OR CREMATORIUM MORGAN CHAPEL CEMETERY		22d. LOCATION (City, town, or county) WOODBINE, CARROLL COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey,		24a. REC'D BY REGISTRAR DATE 3/25/57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE William J. Curry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03070

03091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
Montgomery		a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Montg.					
Olney		c. LENGTH OF STAY IN 1b 19 hrs					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Montg. Co. Gen		d. STREET ADDRESS 611 Stonestreet Ave.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Walter	Middle Geddings				
4. DATE OF DEATH		Month March	Day 18				
5. SEX		6. COLOR OR RACE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1932	9. AGE (in years at birthday) 23 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Geddings		14. MOTHER'S MAIDEN NAME Nellie Florence		Address Hospital Records			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
						Gas Infection DUE TO 781X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c)	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) shot in abdomen		20c. TIME OF INJURY Month, Day, Year Hour 2:00 <input checked="" type="checkbox"/> 3/16 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm		20f. (City or town) Gaithersburg	
						(County) Montg.	
						(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/18/57			
EXAMINER'S NAME (Type) Frank J. Broschart							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/57		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		22d. LOCATION (City, town, or county) (State) Mt. Zion, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR MAR 26 1957		24b. REGISTRAR'S SIGNATURE <i>Gertrude Lawless</i>	

REPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS A15ME(S)
5M 9/55

LETAU V. S.

MAR 20 1957

KESV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03071

03095 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb one day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 3200 33rd St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edward		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 26 April 1888	9. AGE (In years lost, birthday yrs 60)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Robert Banks Gibson		14. MOTHER'S MAIDEN NAME Ella Banks						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes 6-25-06 to 6-1-31		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Sallie Peirce Gibson (Same as #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X		Pulmonary embolus		INTERVAL BETWEEN ONSET AND DEATH immediate				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Congestive heart failure		2 weeks				
DUE TO		(c) Hypertensive arteriosclerotic cardiovascular disease		Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mesenteric Thrombosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arlington, Va.		(County)		(State)
21. I certify that I attended the deceased from 31 March 1957 to 31 March 1976, that I last saw the deceased alive on 31 March 1957, and that death occurred at 6:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE: Russell Miller, Jr. LT, MC, USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.					DATE SIGNED 4-1-77	
PHYSICIAN'S NAME (Type) RUSSELL MILLER, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington, Va.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Lumley		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-1-57		24b. REGISTRAR'S SIGNATURE Russell		

BUREAU V. S

APR 6

REGULUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03072

03096

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X? Bethesda		d. STREET ADDRESS 4401 East-West Highway		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4401 East-West Highway				d. STREET ADDRESS 4401 East-West Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First AGNES	Middle J.	Last GOLUBUSKI		4. DATE OF DEATH March 15,	Month March	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1870	9. AGE (In years last birthday) 87 yrs	10. IF UNDER 1 YEAR 1 Month	11. IF UNDER 24 HRS 24 Hours	12. IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Andrew Moskwa				14. MOTHER'S MAIDEN NAME Anna Adamczyk				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Anne A. Gelumbis-Item# 2		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH 2 wks.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>57</u> , to <u>3-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/15/</u> , 19 <u>57</u> , and that death occurred at <u>2 P M</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Paul D. Cantor</i>		ADDRESS (Street, city or town, state) M.D.						DATE SIGNED Mch 16, 1957
PHYSICIAN'S NAME (Type)		Paul D. Cantor 4709 Montgomery Lane, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 3/18/1957		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) New Castle Co. Delaware		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-18-57		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filled in
by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MAR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03031 Iters 7, 10a CERTIFICATE OF DEATH03073
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Springs		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San & Hospital		e. STREET ADDRESS 10703 St Margaret's Way		f. DATE OF DEATH 3 28 1957		g. AGE (In years last birthday) 89 yrs.		h. IF UNDER 1 YEAR Months 2 Days 3 Hours 0 Min.		i. IF UNDER 24 HRS.	
3. NAME OF DECEASED (Type or print) Robert X.		First Shirley Grandstaff		Middle		Last		j. DATE OF BIRTH 8/25/68		k. IF UNDER 1 YEAR Months 2 Days 3 Hours 0 Min.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/25/68		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 24 HRS. Months 2 Days 3 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Joseph T. Grandstaff		14. MOTHER'S MAIDEN NAME Louise Williams									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Lerenice State				1 yr			
446X		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) Renal Arteriosclerosis				10 yrs			
		DUE TO		(c) Generalized Arteriosclerosis				20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from March 17, 1957 to March 28, 1957 that I last saw the deceased alive on March 27, 1957, and that death occurred at 5:25 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>James H. Whitbeck</i>		M.D.		7600 Carroll Lane		3-28-57					
PHYSICIAN'S NAME (Type)				Takoma Park, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/30/57		22c. NAME OF CEMETERY OR CREMATORIUM Edge Hill		22d. LOCATION (City, town, or county) Charles Town, W. Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Humphrey</i>		ADDRESS 7557 Wisconsin Ave.		24a. REC'D BY REGISTRAR DATE 3/30/57		24b. REGISTRAR'S SIGNATURE <i>William R. D.</i>					

BUREAU V. 2

APR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03097

CERTIFICATE OF DEATH

03074
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived first if on residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 111 days	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 1911 East West Highway	
3. NAME OF DECEASED (Type or print) Marilyn		First Marilyn	Middle (none)
4. DATE OF DEATH March 6, 1957		Month March	Day 6
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gustav Steiner	
14. MOTHER'S MAIDEN NAME Bess Leiner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO 047-12-0105		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Hepatic Decompensation</i> <i>metastatic carcinoma of Breast</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) NEW YORK		(County) N.Y.	
(State) N.Y.			
21. I certify that I attended the deceased from November 15, 1956 to March 6, 1957 , that I last saw the deceased alive on March 6, 1957 , and that death occurred at 9:43 A.M. from the causes and on the date stated above			
ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>William J. Pieper</u> M.D.			
PHYSICIAN'S NAME (Type) William J. Pieper, M.D.			
DATE SIGNED 3/6/57			
22a. BURIAL, CREMATION OR REMOVAL (Specify) MARCH 8, 1957		22b. DATE THEREOF LINDEN HILL	
22c. NAME OF CEMETERY OR CREMATORIUM LINDEN HILL		22d. LOCATION (City, town, or county) NEW YORK	
(State) N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS		24a. REC'D BY REGISTRAR DATE 3-11-57	
ADDRESS 3501-1407 NW		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGEAU V. S.

MAR 10 1955

REGEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03098

03075

CERTIFICATE OF DEATH

Reg. Dist. No. C

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seeley Lake</i>			c. LENGTH OF STAY IN 1b <i>7 months</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U.S. Naval Hospital, Bethesda, Md.</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Charles</i>	Middle <i>Ross</i>	Last <i>GREENING</i>	4. DATE OF DEATH <i>March 29 1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-14</i>	9. AGE (In years less than 1 year) <i>42 yrs.</i>	10. IF UNDER 1 YEAR Months <i>42 yrs.</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Aviator</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Air Force</i>			11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		
13. FATHER'S NAME <i>Charles W. Greening</i>			14. MOTHER'S MAIDEN NAME <i>Jewell Ross</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>Yes, June 1936 to 3-29-57</i>			16. SOCIAL SECURITY NO <i>483 48 4247</i>			17. INFORMANT <i>(Wife) Mrs. Dorothy W. Greening (Same As #2)</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>490.0 Hemorrhage, complication of operation for</i>								
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>								
(b) <i>Arterio insufficiency</i>			1 yr.					
(c) <i>Bacterial Endocarditis</i>			2 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <i>Montgomery</i>					
(County) <i>Montgomery</i>			(State) <i>MD</i>					
21. I certify that I attended the deceased from <i>31 Aug. 1956</i> to <i>29 March 1957</i> that I last saw the deceased alive on <i>26 March 1957</i> , and that death occurred at <i>4:00 A.M.</i> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <i>MD J.S. Naval Hospital, Bethesda, Md. 3-29-57</i>					
ACTUAL SIGNATURE <i>R.P. Osborne</i>			DATE SIGNED					
PHYSICIAN'S NAME (Type) <i>D.P. OSBORNE, CDR, MC, USN</i>			U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-4-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Cemetery</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Pumphrey</i>			ADDRESS <i>R.A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>3-29-57</i>			
					24b. REGISTRAR'S SIGNATURE <i>Gray L. Tassell</i>			

EAU V. 2

10R 4 1957

EGEIV EGD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03099

CERTIFICATE OF DEATH

03076

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Mont.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Wash.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dover Spring Md</i>		c. LENGTH OF STAY IN 1b <i>9 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Green's Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4326 3rd N.W.	
3. NAME OF DECEASED (Type or print) <i>Cynthia (None) Gritton</i>		4. DATE OF DEATH Mar. 22 1957	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3 July 1868</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Denville Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Patrick Doley</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John S. Mansuy 910 Bradford Rd Silver Spring</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hyperthyroid heart disease</i>		DUE TO <i>Generalized arteriosclerosis</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas D. Mattingly M.D.</i>		ADDRESS (Street, city or town, state) M.D. 2200 R.I. Ave. NE. Wash. D.C. DATE SIGNED <i>22 March 57</i>	
22a. BURIAL, CREMATION OR Cremation (check one) <i>Burial</i>		22b. DATE THEREOF <i>3-25-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee Son - Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>3/26/57</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Z. L. Botten</i>	

RECEIVED
BUREAU V. A.

MAR 27 1957

RECEIVED MAR 27 1957
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03077

03100

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 6911 Strathmore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle GALLAHER	Last HALE
4. DATE OF DEATH	Month March	Month 21, 1957	Day 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1869
9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 29	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Gallaher		14. MOTHER'S MAIDEN NAME Fannie Ainsworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT R.D. Hale-735 West Ave.-Cartersville, Ga.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Clogged arteries due to metastatic cancer of liver or biliary system Primary site unknown		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Generalized Arteriosclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 1957, to March 21, 1957, that I last saw the deceased alive on March 21, 1957, and that death occurred at 1 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Arthur F. Woodward</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Arthur F. Woodward- Rockville, Maryland DATE SIGNED <i>Rockville, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/22/57	
22c. NAME OF CEMETERY OR CREMATORIAL West View		22d. LOCATION (City, town, or county) Atlanta, Georgia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-25-57	
		24b. REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

MAR 2 1967

65-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03101

CERTIFICATE OF DEATH

03078

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 14 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. STREET ADDRESS Sandy Spring		
3. NAME OF DECEASED (Type or print) Roy		First William	Middle Hall	
4. DATE OF DEATH March 14 1957	Month March	Day 14	Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/19	
9. AGE (In years last birthday) 37 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chester Hall	14. MOTHER'S MAIDEN NAME Bessie Marr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or date of service)	17. INFORMANT Hospital Record	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 1154 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of rt Adrenal (c) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH 6 mo				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sandy Spring	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 11/01/56 to 14 Mar 1957 , that I last saw the deceased alive on 13 Mar 1957 , and that death occurred at 8:04 AM , from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) Sandy Spring, Md.				DATE SIGNED
ACTUAL SIGNATURE C. H. Ligon, M. D.				
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/18/57	22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial	22d. LOCATION (City, town, or county) Sandy Spring, Md.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden - Rockville, Md.		ADDRESS Robert L. Snowden - Rockville, Md.	24a. REC'D BY REGISTRAR 3-17-57	24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler

UREAU V. S.

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03102

CERTIFICATE OF DEATH

03079

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2228 - 40th Place, N. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Laura		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 21, 1900	9. AGE (in years at birthday) 56 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk		10b. KIND OF BUSINESS OR INDUSTRY Renegotiation Board		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Sidney Hawkins		14. MOTHER'S MAIDEN NAME Willie Lou Gibbs						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 204.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Gastro intestinal bleeding		INTERVAL BETWEEN ONSET AND DEATH 1 week		
DUE TO Acute Myelogenous Leukemia (c)						4 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral Lower lobe Atalectasis; Multiple Abscesses						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from February 18, 1957, to March 31, 1957, that I last saw the deceased alive on March 31, 1957, and that death occurred at 8.30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE John Laszlo		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland		ADDRESS (Street, city or town, state) 3/31/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/57		22c. NAME OF CEMETERY OR CREMATORIUM Oakwood Cemetery		22d. LOCATION (City, town, or county) Waco		(State) Texas
23. FUNERAL DIRECTOR'S SIGNATURE Joseph S. Dawkins, Son		ADDRESS 1756 Pennsylvania Ave NW, Washington, DC		24a. REC'D BY REGISTRAR DATE 4-8-57		24b. REGISTRAR'S SIGNATURE Berrie M. Thompson		

BUREAU V. S.

APR 5 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03080

03032

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
Montgomery				a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Montgomery					
Takoma Park, Md.		13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Washington Sanitarium & Hospital		8007 Park Crest Drive							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH				
ANNA		CATHERINE HEIM		March 25 1957					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years from last birthday) 76 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HRS Hours	13. MIN
female	white		7-19-80						
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own home		District of Columbia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Gustav E. Rott		Ida Hartig							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		NONE		Mrs Carl F. Cozzee		55, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cirrhosis of liver				INTERVAL BETWEEN ONSET AND DEATH 2 years			
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Wash. D. C.	(County)	(State)		
21. I certify that I attended the deceased from		March 1955, to Mar. 25, 1957		that I last saw the deceased alive on Mar. 25, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city, or town, state)		DATE SIGNED 3/25/57	
ACTUAL SIGNATURE		C. Willard Camalier Jr. M.D.		1801-Eye St., N.W.					
PHYSICIAN'S NAME (Type)		C. WILLARD CAMALIER, JR.		Wash. D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/57		22c. NAME OF CEMETERY OR CREMATORIAL ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hernan E. Murphy		ADDRESS 8434 Yale St., Md.		24a. REG'D BY REGISTRAR DATE 3/29/57		24b. REGISTRAR'S SIGNATURE G. Willard Rott			

BUREAU Y. A.

APR 2 1957

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03081

03103

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		d. STREET ADDRESS 1325 Longfellow St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GLADYS	Middle E.	Last HENDERSON	4. DATE OF DEATH March 8,	Month Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 28, 1889	9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 8 Days 10 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secy.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME R. Milton Henderson		14. MOTHER'S MAIDEN NAME Lilly Petrola			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rebecca A. Sibley-3907 Aspen St, Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Reproductive Failure Malnutrition Amyotrophic Lateral Sclerosis		Address 12 hrs. 6 mo. 2 yrs. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 1/23, 1956, to 3/8, 1957, that I last saw the deceased alive on 3/8, 1957, and that death occurred at 8 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED 3/9/57	
ACTUAL SIGNATURE Frank Jaggers M.D.					
PHYSICIAN'S NAME (Type) Frank Jaggers		5707 Wis. Ave., Chevy Chase, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/57		22c. NAME OF CEMETERY OR CREMATORIAL Congressional	
22d. LOCATION (City, town, or county) Washington, D. C.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-11-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03104 CERTIFICATE OF DEATH

03082

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS Parkside Apts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kenneth	Middle L.	Last Henderson
4. DATE OF DEATH	Month March	Day 3,	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1902
9. AGE (In years last birthday) 54 yrs	10. IF UNDER 1 YEAR 11 months	11. IF UNDER 24 HRS. 12 hours	12. IF UNDER 24 HRS. 13 min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Merchandising	11. BIRTHPLACE (State or foreign country) White Plains, N. Y.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Henry C. Henderson	14. MOTHER'S MAIDEN NAME Annie Randell	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO 578-36-5285	17. INFORMANT Wife	Address Parkside Apts.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-renal failure		INTERVAL BETWEEN ONSET AND DEATH 10 day	
DUE TO Coronary sclerosis		DUE TO 5 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Generalized marked arterio sclerosis nucleoplasm		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) March (County) Westchester County (State) N. Y.	
21. I certify that I attended the deceased from March 2, 1957 to March 2, 1957 , that I last saw the deceased alive on March 2, 1957 , and that death occurred at 5:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert G. Taylor</i>		ADDRESS (Street, city or town, state) 156 E. Washington Ave., Elmsford, N. Y. DATE SIGNED March 2, 1957	
PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-7-57		22b. DATE THEREOF 3-7-57	
22c. NAME OF CEMETERY OR CREMATORIUM Kenisco Cemetery		22d. LOCATION (City, town, or county) Westchester County, N. Y. (State) N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Humphrey</i>		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 8-5-57		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

MAR 7 1957

REGISTRATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03083 24
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedarcroft Sanatorium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
3. NAME OF DECEASED (Type or print) Lillian		d. STREET ADDRESS 4209 41st N.W.	
5. SEX female		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Mar. 1, 1913	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) D.C.	
13. FATHER'S NAME Thomas J. Hoy		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Laurence Higgins Same as Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to vomitus		Address INTERVAL BETWEEN ONSET AND DEATH D.O.A.	
DUE TO Conditions, if any, which gave rise to immediate cause (b) Alcoholism			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	Frank J. Broschart		DATE SIGNED Mar. 3, 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-57	
22c. NAME OF CEMETERY OR CREMATORIAL mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins 3821-14th N.W. Wash. D.C.		ADDRESS 24a. REC'D BY REGISTRAR DATE 3/5/57	
		24b. REGISTRAR'S SIGNATURE Francis J. Collins	

BUREAU V. S.

Mar. 15, 1947

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03033 03084
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5902 Kingwood Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Ide</u>	Middle <u>Jeanette</u>	Last <u>Hines</u>	4. DATE OF DEATH	Month <u>March</u>	Day <u>17</u>	Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-91</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	10. IF UNDER 1 YEAR Months <u>6</u>	11. IF UNDER 24 HRS. Days <u>5</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Perry</u>		14. MOTHER'S M AIDEN NAME <u>Sadonia Diggs</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>610-12-1212</u>		17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		<u>Generalized Carcinomatosis</u> <u>Cancer of the pancreas</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1124A</u>		20f. (City or town) (County) (State) <u>Spotsylvania County, Va.</u>	
21. I certify that I attended the deceased from <u>3/17/57</u> to <u>3/17/57</u> , 1957, that I last saw the deceased alive on <u>3/17/57</u> , 1957, and that death occurred at <u>1124A</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Chas H. Wilson</u>				ADDRESS (Street, city or town, state) <u>Spotsylvania County, Va.</u>		DATE SIGNED <u>3/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/19/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Salem Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Spotsylvania County, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D.C.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>3/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03034 CERTIFICATE OF DEATH

03085
223

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 hrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D. C.</u>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>		d. STREET ADDRESS <u>607 Whittier St., N.W.</u>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <u>Alice</u>		First <u>Alice</u>	Middle <u>Salina</u>	Last <u>Hodge</u>	4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3 - 6 - 72</u>	9. AGE (In years last birthday) yrs. <u>85</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>James Seawell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cavann</u>		Address <u>Washington Sanitarium + Hospital Park</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <u>Hemorrhage massive into stomach</u>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <u>Leptic ulcer, chronic, active, stomach</u>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury of Part 1 or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Gloucester County, Virginia</u> (County) <u>Gloucester County, Virginia</u> (State)
21. I certify that I attended the deceased from <u>March 11, 1957</u> to <u>March 11, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>113 Carroll St NW, Wash 12, DC</u>		ACTUAL SIGNATURE <u>Dean H Harding</u>		M.D. <u>Same</u>		DATE SIGNED <u>3/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Providence Baptist Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Gloucester County, Virginia</u>		(State)	
23. FUNERAL-DIRECTOR'S SIGNATURE <u>J. Arthur Wallis</u>		ADDRESS <u>254 Carroll St NW, DC</u>		24a. REC'D BY REGISTRAR <u>J. McMurphy</u>		24b. REGISTRAR'S SIGNATURE <u>J. McMurphy</u>		DATE <u>3/13/57</u>	

RECEIVED
BUREAU V. 8

MAR 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086

216

03106

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>MONTGOMERY</i>	
c. LENGTH OF STAY IN 1b <i>20 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN HOSP. TA</i>		d. STREET ADDRESS <i>1816 THAYER AVE</i>	
3. NAME OF DECEASED (Type or print) <i>AUGUST</i>		4. DATE OF DEATH <i>MARCH 16 1957</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>WHITE</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-7-1887</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) <i>69 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NIGHT WATCHMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MD. UNIVERSITY</i>	
11. BIRTHPLACE (State or foreign country) <i>RHODE ISLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>NOT AVAILABLE</i>		14. MOTHER'S MAIDEN NAME <i>NOT AVAILABLE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-22-1135</i>	
17. INFORMANT <i>Mrs. AMELIA T. HOLZMER</i>		Address <i>(SAME AS #2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Right hemiplegia</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterosclerosis, generalized DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of bladder</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>(State)</i>	
21. I certify that I attended the deceased from <i>August 7, 1954</i> , to <i>March 15, 1957</i> , that I last saw the deceased alive on <i>March 15, 1957</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Aaron H. Traum</i> M.D. ADDRESS (Street, city or town, state) <i>8237 Georgia Avenue, Silver Spring, Md.</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Aaron H. Traum, M. D.</i>		March 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 19-1957</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bethesda, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Arthur Walters</i>		ADDRESS <i>254 Carroll Dr. NW, DC</i>	
24a. REG'D BY REGISTRAR <i>R. 18/1957</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>	

CHARLES V. S.

MAR 19 1957

COLLEGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03107

CERTIFICATE OF DEATH

03087
217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>MARYLAND</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>6 days</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. STREET ADDRESS <i>Silver Spring RFD #1</i>					
3. NAME OF DECEASED (Type or print) <i>Irene Smith</i>		First <i>Irene</i>	Middle <i>Smith</i>				
4. DATE OF DEATH <i>3-21-1957</i>	Month <i>3</i>	Day <i>21</i>	Year <i>1957</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-17-10</i>				
9. AGE (In years last birthday) <i>47 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	12. IF UNDER 24 HRS Min <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>ISSAC YOUNG</i>	14. MOTHER'S MAIDEN NAME <i>LOTTIE Fisher</i>	Address <i>George (husband) RFD #1 Silver Spring, Md.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i></i>	16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i></i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Chronic Pulmonary Tuberculosis and Chronic Tuberculous Peritonitis</i>	INTERVAL BETWEEN ONSET AND DEATH <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i></i>			20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>3-15-1957</i> to <i>3-21-1957</i> , that I last saw the deceased alive on <i>3-20-1957</i> , and that death occurred on <i>3-21-1957</i> at <i>8:20 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Witowski Jr. M.D.</i>	ADDRESS (Street, city or town, state) <i>Suite 400, 8218 Wisconsin Ave.</i>			DATE SIGNED <i>3/21/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ash Memorial</i>	22d. LOCATION (City, town or county) <i>Sandy Spring, Md.</i>	(State) <i></i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>	ADDRESS <i>Rockville, Md.</i>	24a. REC'D. BY REGISTRAR <i>MAR 27 1957</i>	24b. DATE <i></i>	REGISTRAR'S SIGNATURE <i>Beesie Thompson</i>			
VS A15 (4) 15M 9/55							

BUREAU Y. S.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03108

CERTIFICATE OF DEATH

03088
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY 418	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 mos.	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4801 Conn Ave. N.W.	
d. STREET ADDRESS WASHINGTON		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK PRENETTE HOOVER		First	Middle
4. DATE OF DEATH March 13 1957		Last	Month
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JULY 18 1875		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
13. FATHER'S NAME William Hoover		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 410.1 (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SENILITY		20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m. 19	
20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21 1957 to March 13 1957 , that I last saw the deceased alive on March 13 1957 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		ADDRESS (Street, city or town, state) 5206 Normandy Dr. March 13, 1957 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/57	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE St. H. Jones Cremation Washington, D. C.		24a. REC'D BY REGISTRAR DATE MAR 15 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Frances Patterson	

RECEIVE

MAR 15 1977

DUPLICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03089

03109

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA 14		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 24 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		d. STREET ADDRESS 8515 - HOOD STREET	
3. NAME OF DECEASED (Type or print) FRANCIS		First J.	Middle HORAN
4. DATE OF DEATH MARCH 21 1957	Month MARCH	Day 21	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3 - 1900
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not rec'd) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVT.	11. BIRTHPLACE (State or foreign country) DIST. OF COLUMBIA	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME TIMOTHY HORAN	14. MOTHER'S MAIDEN NAME VAHNAEEN ABBIE FOLEY	Address 8515 Hood St.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. —	17. INFORMANT MRS. CHRISTINA I. HORAN TAKOMA PK., MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
420.1 DUE TO Coronary Occlusion & Thrombosis Left Coronary Artery			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Atherosclerosis			
(c) DUE TO Generalized Atherosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Pulmonary Edema & Bilateral Planar effusion			
19. MEDICAL CERTIFICATION	20a. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	20c. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Silver Spring, Md. (County) Montgomery (State) Md.
21. I certify that I attended the deceased from 20 March, 1957 to 21 March, 1957 , that I last saw the deceased alive on 21 March, 1957 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Merton L. White	ADDRESS (Street, city or town, state) 11134 Greenberg Ave. At 11th & 11th Sts. DATE SIGNED 3-25-57		
PHYSICIAN'S NAME (Type) Merton L. White			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-25-57	22c. NAME OF CEMETERY OR CREMATORIAL State of Heaven	22d. LOCATION (City, town, or county) Silver Spring, Md. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins 3821-14th St. NW Wash. D.C.	ADDRESS 3821-14th St. NW Wash. D.C.	24a. REC'D BY REGISTRAR 8-25-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

RECEIVED
BUREAU V. S.

MAR 6 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03035

CERTIFICATE OF DEATH

03090

Reg. Dist. No. 2203

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		16 15-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodlawn Sanitarium and Hospital		d. STREET ADDRESS 2203 Guilford Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Girl		First	Middle	Last	4. DATE OF DEATH 3	Month	Day 17	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-17-57	9. AGE (In years lost birthday) yrs. 0	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? N. America			
13. FATHER'S NAME Roger William Houser			14. MOTHER'S MAIDEN NAME Katherine Earl Hullinger			Address Father, 2203 Guilford Road, W. Hyattsville, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO 1961-5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Prematurity DUE TO (c) Placenta Previa			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19. INTERVAL BETWEEN ONSET AND DEATH (Present at birth)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Takoma Park		(County) Prince Georges	(State) Maryland
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 925 Pershing Dr., Silver Spring, Md. 3-18-57							DATE SIGNED
ACTUAL SIGNATURE Raymond Chinn, M.D.									
PHYSICIAN'S NAME (Type) Raymond Chinn, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3-18-57		22c. NAME OF CEMETERY OR CREMATORIAL Washington San. & Hospital		22d. LOCATION (City, town, or county) Takoma Park, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D.		ADDRESS Wash. San. & Hosp.		24a. REC'D BY REGISTRAR DATE 3-19-57		24b. REC'D STRAIGHT'S SIGNATURE J. E. C. Hare, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03110

CERTIFICATE OF DEATH

03091
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 15 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 PHILADELPHIA AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
3. NAME OF DECEASED (Type or print)		First	Middle
Emily		L	Hudnut
4. DATE OF DEATH		Month	Day
MARCH 3		1957	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
FEMALE		WHITE	8. DATE OF BIRTH DEC. 5, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) PATTERSON, N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM L. ALLISON		14. MOTHER'S MAIDEN NAME ELLEN LOMBARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT RUTH HUDNUT
		Address 507 S. W. 3D, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 14.10.0		3 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		10 yrs	
DUE TO (b)		20 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>Jan</u> , 1946, to <u>March 3</u> , 1957, that I last saw the deceased alive on <u>March 3</u> , 1957, and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7832 16th & 4th, West 12	
ACTUAL SIGNATURE H. F. Kreuzburg		DATE SIGNED 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/57	22c. NAME OF CEMETERY OR CREMATORIUM Geo. Wash Mem
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamberlain, Silverdale, Md.		24a. RECD BY REGISTRAR MARCH 5, 1957	24b. REGISTRAR'S SIGNATURE Lance L. Lott

BURIAU V. S.

1948

MECHANIC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03092

03111 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 16 Since Aug. '56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA REST HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING,	
3. NAME OF DECEASED (Type or print) HELENE		First CATHERINE	Middle HUGHES
4. DATE OF DEATH MARCH 21 1957	Month Day Year	d. STREET ADDRESS 10,613 EASTWOOD AVENUE	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/91
9. AGE (In years last birthday) 65		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN KERN BENTLEY	
14. MOTHER'S MAIDEN NAME MARY ELLEN MACBURY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. YES		17. INFORMANT Mrs. Walter C. Hughes, Jr., 10,613 Eastwood Ave. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1956, to <u>March 21</u> , 1957, that I last saw the deceased alive on <u>March 20</u> , 1957, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>W.M.F. Greaney</u>		ADDRESS (Street, city or town, state) M.D. 7642 12 38th Ave Washington 12 DC DATE SIGNED	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/23/57	22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		24a. REC'D BY REGISTRAR DATE 3/26/57	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren L. Lumpkin</u>		24b. REGISTRAR'S SIGNATURE <u>Frances P. Potts</u>	ADDRESS SILVER SPRING, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

لَهُ دَرْكُهُ مَهْرَبُهُ . . . وَهُوَ مَهْرَبُهُ أَنْ تَرَهُ شَهْرُ
مَهْرَبِهِ . . . مَهْرَبُهُ حَوْلَهُ كَمْ مَهْرَبُهُ حَوْلَهُ . . .
مَهْرَبُهُ دَعْوَهُ . . . مَهْرَبُهُ دَعْوَهُ . . . مَهْرَبُهُ دَعْوَهُ

كَلْمَةُ الْمَهْرَبِ
كَلْمَةُ الْمَهْرَبِ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03093

03112

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Washington, D. C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 11/2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital, 8600 Georgetown Rd., Bethesda, Md.				d. STREET ADDRESS 4125 Harrison Street, N.W., Washington, D. C.		e. IS RESIDENCE a. FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mark	Middle Leslie	Last Hull	4. DATE OF DEATH March 13, 1957	Month March	Day 13	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1893	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Hours 13	12. IF FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer's Occupation		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOC. SEC. SECURITY NO. Unknown		17. INFORMANT Turco, MRS Angelina - Friend. Address (Above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO		1/2 my cardiac infarction Coronary Occlusion Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 20</u> , 1957, to <u>13 March</u> 1957, that I last saw the deceased alive on <u>13 March</u> , 1957, and that death occurred at <u>11:25 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE John G. Ball M.D.						ADDRESS (Street, city or town, state) 7936 Georgetown Rd., March 14/57 Bethesda - 14 Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/14/1957		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-16-57		24b. REGISTRAR'S SIGNATURE Benjie M. Hwang	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

MAR 17 1957

REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03094

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
3. NAME OF DECEASED (Type or print) Jules		First (nnn) JAMES	4. DATE OF DEATH March 12 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 14 Feb. 1885	9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John James		14. MOTHER'S MAIDEN NAME Ann Maria Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes 6-9-04 to 11-1-46		16. SOCIAL SECURITY NO Unknown	17. INFORMANT Official Navy Records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Emphysema, Pulmonary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 10-11 hours				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11 March</u> , 19 57, to <u>12 March</u> , 19 57, that I last saw the deceased alive on <u>12 March</u> , 19 57, and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____				
ACTUAL SIGNATURE <u>Bruce L. Canaga</u> M.D. U.S. Naval Hospital, Bethesda, Md. 3-13-57				
PHYSICIAN'S NAME (Type) BRUCE L. CANAGA, JR. CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-57	22c. NAME OF CEMETERY OR CREMATORIUM Greenhill Cemetery	22d. LOCATION (City, town, or county) Danville, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons</u> Gawler's & Sons, 1756 Penn Ave., N.W. Wash.D.C.		ADDRESS	24a. REC'D BY REGISTRAR DATE 3-13-57	24b. REGISTRAR'S SIGNATURE <u>Joseph G. Canally</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be attached for use as the burial-transit permit. This will remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 15 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03095

03/14

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 4847 Crescent St. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle J	Last JOHNSON	4. DATE OF DEATH	Month March	Day 3,	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1878	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Meat Merchant		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joshua Johnson				14. MOTHER'S MAIDEN NAME Veronica Wood				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Belle B. Johnson, Same as # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN DUE TO 1 hr. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary heart disease & advanced peripheral atherosclerosis. DUE TO 10 yrs. (c) Diabetes mellitus 3 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D.C.	(County) District of Columbia	(State) D.C.
21. I certify that I attended the deceased from Dec. 1, 1951 to 3/3, 1957 , that I last saw the deceased alive on 3/2, 1957 , and that death occurred at 4:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. A. Thomas</i>								
PHYSICIAN'S NAME (Type) S. A. THOMAS, M.D.				ADDRESS (Street, city or town, state) 4801-48th St. N.W.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF/TON. 3/6/57		22c. NAME OF CEMETERY OR CREMATORIUM Geo. Washington Cem.		22d. LOCATION (City, town, or county) Hyattsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gavels Sons Inc.</i>				ADDRESS 1756 Pa. Ave., N.W.		24a. REC'D BY REGISTRAR 3-6-57		
						24b. REGISTRAR'S SIGNATURE <i>Bessie W. Thompson</i>		

RECEIVED
BUREAU V. S.

MAR 8 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03115

CERTIFICATE OF DEATH

03096

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 15 HRS.		a. STATE b. COUNTY		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 6111 UTAH AVE. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		SUBURBAN HOSPITAL		7.4		
3. NAME OF DECEASED (Type or print)		First	Middle	8. DATE OF DEATH Johnson	Month Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH JUNE 24 1877	10. AGE (In years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY ASSESSOR		11. BIRTHPLACE (State or foreign country) VIRGINIA		
13. FATHER'S NAME VALENTINE MASON		14. MOTHER'S MOTHER'S MAIDEN NAME Johnson		12. CITIZEN OF WHAT COUNTRY U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Livingston L. Johnson		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 4572-49TH ST. N.W. WASH. D.C.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure 4 mos.				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Arterio sclerotic Heart Disease 15 years				
DUE TO (b)						
(c)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov 23, 1956 to March 12, 1957, that I last saw the deceased alive on March 11, 1957, and that death occurred at 5:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) Robert B. Havell ADDRESS (Street, city or town, state) M.D. 5516 Neb. Ave. D DATE SIGNED 3-12-57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/57		22c. NAME OF CEMETERY OR CREMATORIAL Maddelung Mem. Cem		
22d. LOCATION (City, town, or county) Maddelung, Va				22e. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home, 5103 Ridge Rd.		ADDRESS DATE 3-15-57		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Bev W. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU. V. S

MAR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03116

CERTIFICATE OF DEATH

03097

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3702 East Bradley Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3702 East Bradley Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Dorothy		First	Middle	Last	4. DATE OF DEATH March 2	Month	Day	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1904	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 26	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James B. McAlpine		14. MOTHER'S MAIDEN NAME Anne Peel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Anne Pruitt - 7316 Bath St. Springfield, Wash 16		Address D. C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Carcinoma of Breast				INTERVAL BETWEEN ONSET AND DEATH 4 years		
(b) DUE TO Metastases - generalized		(c)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sep. 11, 1953, to Mch. 2, 1957, that I last saw the deceased alive on Feb. 28, 1957, and that death occurred at 7:50 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 3/2/57		
ACTUAL SIGNATURE Walter Atkinson								
PHYSICIAN'S NAME (Type) Walter Atkinson, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/1957		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek		22d. LOCATION (City, town, or county) Washington		(State) D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-2-57		24b. REGISTRAR'S SIGNATURE Benjamin Thompson		

BUREAU V

MR 5 151

RECORDED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

03098
4/13

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. and Hosp.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. STREET ADDRESS White Oak, Stewart Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Samuel Henry Joppy		First	Middle	Last	4. DATE OF DEATH Mar. 29, 1957
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1918	9. AGE (in years last birthday) 39	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY garbage truck		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Henry Joppy			14. MOTHER'S MAIDEN NAME Annie Neal		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. Records	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH sudden					
423.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 19. WAS AUTOPSY CAUSE OF DEATH. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3/29/57
EXAMINER'S NAME (Type) Frank J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/1/57	22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park,		22d. LOCATION (City, town, or county) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE 4/7/57		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Daddy</i>

BUREAU V. S

APR 3 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Rep. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 24 hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph		Middle Justus		4. DATE OF DEATH Mar. 21, 1957	Month Mar. Day 21 Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/93	9. AGE (in years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY USA.			13. FATHER'S NAME August Justus		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. WW #1			17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					
DUE TO Fracture of Skull					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell backward down steps			
20c. TIME OF INJURY 6:30 p.m. 3/20/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Silver Spring		(County) Montg. Md.		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>			DATE SIGNED Mar. 21, 1957		
EXAMINER'S NAME (Type) Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/26/57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)		22e. REC'D BY REGISTRAR DATE 3/25/57	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Pamphrey</i>			24b. REGISTRAR'S SIGNATURE <i>W. Broschart</i>		
ADDRESS Silver Spring 8434 1/2 Ave NW			24a. REC'D BY REGISTRAR DATE 3/25/57		

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

OR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to removal, or removal.

BUREAU V. A.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03117

CERTIFICATE OF DEATH

03117
216

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Pazewell	
c. LENGTH OF STAY IN 1b 108 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raven	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Box 563	
e. 15 RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Lycurgus	4. DATE OF DEATH Month March Year 27, 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1878
9. AGE (In years lost on birthday) 78 yrs		10. IF UNDER 1 YEAR Months 4 Days 26 Hours 0 Mins 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
10c. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Justus		14. MOTHER'S MAIDEN NAME Sarah Ledgewood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) Yes		16. SOCIAL SECURITY NO not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EDema DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause lost (b) Uremia (c) Chronic Nephritis			
INTERVAL BETWEEN ONSET AND DEATH 3 hrs.			
3 days			
Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myeloid Metaplasia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1956, to March 27, 1957, that I last saw the deceased alive on March 27, 1957, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Nathans		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Daniel Nathans, M. D.		DATE SIGNED 3/28/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 3/28/57		22b. DATE THEREOF Richlands	
22c. NAME OF CEMETERY OR CREMATORIAL Richlands		22d. LOCATION (City, town, or county) Richlands, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-28-67	
		24b. REGISTRAR'S SIGNATURE Benjamin M. Horwitz, M.D.	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y-2

APR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03118

CERTIFICATE OF DEATH

Reg. Dist. No.

03118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 months.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9405 SEMINOLE ST.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
3. NAME OF DECEASED (Type or print) ANNIE GENEVIEVE KEEGIN		4. DATE OF DEATH MARCH 1 1957	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. SEX Female	7. COLOR OR RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 01.21.1876		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joseph Francis Keim (KIEM)	14. MOTHER'S MAIDEN NAME MARY NEIDEMEIR	Address Silver Spring Ind.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Joseph Keegan	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 months			
DUE TO (b) Arteriosclerosis		2 years			
DUE TO (c) Arteriosclerosis		years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Occlusion					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —			
20c. TIME OF INJURY Hour o. p. n. p. m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> —	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from June 1955 to February 1957 , that I last saw the deceased alive on Feb 24 1957 , and that death occurred at 14 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Md.					
ACTUAL SIGNATURE Richard A. Yates	M.D. Richard A. Yates	DATE SIGNED 3/1/57			
PHYSICIAN'S NAME (Type) RICHARD A. YATES					
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial	22e. DATE THEREOF 3/4/1957	22f. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22g. LOCATION (City, town, or county) Washington, D.C.	(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co - RIVERDALE, Md.	ADDRESS —	24a. REC'D BY REGISTRAR Frances Potters	24b. REGISTRAR'S SIGNATURE Frances Potters		

BUREAU Y. S.

MAR 4 1957

REGELIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

03119 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03102

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN lb 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS RFD # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD # 3				d. STREET ADDRESS RFD # 3					
3. NAME OF DECEASED (Type or print) Mae Bunice Kelchner		First Middle Last		4. DATE OF DEATH Mar. 22. 1957		Month Day Year Mar. 22. 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1904		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph J. Matthews		14. MOTHER'S MAIDEN NAME Nellie G. Huhn							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Paul B. Kelchner, Rockville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH sudden			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion							
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar. 23, 1957			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
NAME (Type) Frank J. Broschart				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-57		22c. NAME OF CEMETERY OR CREMATORIAL Gaithersburg		22d. LOCATION (City, town, or county) Rockville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest J. Jartner.		ADDRESS Gaithersburg		24a. REC'D BY REGISTRAR DATE 3/25/57		24b. REGISTRAR'S SIGNATURE Alma L. Cook			

BUREAU V. S.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1
1957

03103

03120

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		5617 Woodway Circle MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3621 Newark St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Annie	Middle Jones	Last King	4. DATE OF DEATH	Month March	Day 17	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/11/1879	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram Jones		14. MOTHER'S MAIDEN NAME Anna Stewart Fahnestock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Dr. Barry Griffith King		Address Wash 16, DC 5617 Woodway Circle	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 35 Minutes	
DUE TO Chronic Coronary Arterial Disease (c)						3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Weakness from Major Pelvic Surgery 4 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from September 1957 to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 2:16 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 3408 WISCONSIN AVE NW ACTUAL SIGNATURE W.R. Stover PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION Cremation	22b. DATE THEREOF 3/20/57	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Pr. Geo. Co., Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901		ADDRESS 14th St. N.W. Wash. D.C.	24a. REC'D BY REGISTRAR DATE 3-19-57	24b. REGISTRAR'S SIGNATURE Berrie M. Shontz			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03104

03121

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Maryland b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Wilma		Fay		King	Mar 7 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from birthday) yrs
W. female	White			Mar 7-57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Pennsylvania, U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William		Sylvia		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Fee, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				William G. King, Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
1.0 DUE TO <i>infection</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)					
DUE TO <i>prolapsed cord</i>					
DUE TO <i>Breech delivery</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 1956, to <i>March 7</i> , 1957, that I last saw the deceased alive on <i>March 7</i> , 1957, and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Vernon E. Martens</i> M.D. ADDRESS (Street, city or town, state) <i>Germantown, Md.</i> DATE SIGNED					
PHYSICIAN'S NAME (Type) <i>Vernon E. Martens</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>3-8-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>No. 1854, Gaithersburg</i>	
22d. LOCATION (City, town, or county) <i>Gaithersburg</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>Mar 8-57</i>	
<i>Ernest C. Gartner</i>		<i>Gaithersburg, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Abigail G. Cooke</i>	

3.4.1951

1951

3.4.1951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

03122 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03105

Reg. Dist. No. 12

1. PLACE OF DEATH a. COUNTY OYSTER BAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY OYSTER BAY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OYSTER BAY		c. LENGTH OF STAY IN 1b 10 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OYSTER BAY		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OYSTER BAY				
3. NAME OF DECEASED (Type or print) Richard J. Trochart		First Richard	Middle J.			
		Last J. Trochart	4. DATE OF DEATH Mar. 31, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/1928			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Va.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Irvin Floyd Kitts				
14. MOTHER'S MAIDEN NAME Nona Quillers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				
16. SOCIAL SECURITY NO.		17. INFORMANT Police	Address Pooleville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Skull DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pedestrian. Struck by auto.						
20c. TIME OF INJURY Hour 2:00 P.M.	Month, Day, Year 3/31/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) OYSTER BAY	20f. (City or town) OYSTER BAY	(County) Baltimore	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE Frank J. Trochart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3/31/57		
22a. BURIAL/CREMATION/REMOVAL (Specify) 1/2/57	22b. DATE THEREOF 1/2/57	22c. NAME OF CEMETERY OR CREMATORIAL St. Pauls	22d. LOCATION (City, town, or county) Hanover	(State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton	ADDRESS Barnesville, N.Y.	24a. REC'D BY REGISTRAR DATE 4/1/57	24b. REGISTRAR'S SIGNATURE Charles W. Elgin 4/1/57			

BUREAU V. S.

APR 3 1968

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03123
 Item 9 File No. 3-18-57
 CERTIFICATE OF DEATH

03106

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Chevy Chase		f. STREET ADDRESS 4312 Willow Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Addie		First Drullard		Middle Koch		4. DATE OF DEATH March 16 1957	Month March	Day 16	Year 1957
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1873		9. AGE (In years last birthday) 83 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Edward Drullard		14. MOTHER'S MAIDEN NAME Susie McKenna							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown]		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Ross McNeil		Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH [Handwritten text: For much of her life she had been in poor health, gradually deteriorating, especially in the last year.]			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-16-57</u> to <u>3-16-57</u> , 1957, that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u>		DATE SIGNED <u>3/16/57</u>			
ACTUAL SIGNATURE <u>W. T. Joyce, M.D.</u>		PHYSICIAN'S NAME (Type)		8106 Maple Ridge Rd, Bethesda, Md		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3-18-57			
22b. DATE THEREOF Forest Lawn Cemetery		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethesda, Md.		22d. LOCATION (City, town, or county) Erie County, New York		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE 3-18-57		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

BUREAU V.

MAR 31 1957

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1 HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03124

03107

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Poolesville</i>		c. LENGTH OF STAY IN 1b <i>16</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Poolesville x2</i>		d. STREET ADDRESS <i></i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Harry</i>	Middle <i>Kohlhass</i>	Last <i></i>	4. DATE OF DEATH Month <i>March</i>	Month <i>24</i>	Day <i>1957</i>	Year
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/18/1873</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	Hours <i></i>	Min <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Garage owner</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
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13. FATHER'S NAME <i>Charles Kohlhass</i>	14. MOTHER'S MARRIED NAME <i>Ellen Jane Carlisle</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Charles Kohlhass - Poolesville, Md</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
		4 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
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21. I certify that I attended the deceased from <i>20 May 1953</i> to <i>24 Mar 1957</i> , that I last saw the deceased alive on <i>23 March 1957</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.					
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ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>John C. Fawcett</i>	PHYSICIAN'S NAME (Type) <i>John C. Fawcett</i>	M.D. DAWSONVILLE, PA. BAPT 3/24/57	MARYLAND
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/26/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Monocacy</i>	22d. LOCATION (City, town, or county) <i>Bellsville, Md</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hillen, Barnesville, Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>3/26/57</i>	24b. REGISTRAR'S SIGNATURE <i>Charles W. Elgin per ASCE</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03125

CERTIFICATE OF DEATH

13108

Reg. Dist. No. 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 6615 Western Ave N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie	First	Middle	4. DATE OF DEATH March 24 1957	Months	Day
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-76	9. AGE (In years lost birthday) 80 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME Reese		14. MOTHER'S MAIDEN NAME Sara Jones		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Calvert L. Dedrick Address 6615 Western Ave N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebral Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Cerebral Arterio sclerosis		years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16 1957, to March 24 1957, that I last saw the deceased alive on March 23 1957, and that death occurred at 5:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert B. Harrell M.D.		DATE SIGNED 3-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Rodgerville Cemetery		22d. LOCATION (City, town, or county) Rodgerville, his. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-28-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

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MAR 29 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 6 Form No. 4-20-1, et
03126 CERTIFICATE OF DEATH

Reg. Dist. **03101/6**

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 27 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27				
3. NAME OF DECEASED (Type or print) Charlotte		First Charlotte	Middle Isabelle			
4. DATE OF DEATH March 12, 1957		Month March	Day 12			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH March 26, 1904		9. AGE (In years last birthday) 52	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Washington, D. C.			
13. FATHER'S NAME Louis A. Davis		14. MOTHER'S MAIDEN NAME Ruth G. Cooke				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral emboliz left hemisphere		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO subacute soft emboliz						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of cerv						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland	(County) Maryland	(State) MD
21. I certify that I attended the deceased from February 13, 1957 to March 12, 1957 , that I last saw the deceased alive on March 12, 1957 , and that death occurred at 12:00 Midnight , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 3/12/57		
ACTUAL SIGNATURE <i>S. Weissman</i>		M.D.				
PHYSICIAN'S NAME (Type) S. Weissman, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/57	22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cem.	22d. LOCATION (City, town, or county) Suitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 1820 9th St., N.W.		24. REGISTRAR'S SIGNATURE Bev Thompson		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03038

CERTIFICATE OF DEATH

03110

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>315 Pennwood Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium + Hospital</i>				4. DATE OF DEATH Month <i>March</i>		Day Year <i>4 1957</i>	
3. NAME OF DECEASED (Type or print) <i>Mae</i>		First <i>Mae</i>	Middle <i>Caroline</i>	Last <i>Layton</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 13 1875</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Francis Turpin</i>		14. MOTHER'S MAIDEN NAME <i>Love Hackett</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mae L. Downer</i>		Address <i>3007 Erie St. S.E. Wash D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDema - 48 Hrs</i>						INTERVAL BETWEEN ONSET AND DEATH <i>48 Hrs</i>	
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Hypostatic Pneumonia Bilateral</i>		(b) DUE TO <i>General Hemorrhage (Left) - 96 Hrs</i>					
(c) DUE TO <i>ARTERIOSCLEROSIS CON DIABETES MELLITUS Hypertension</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1943</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4316-14th Street - 311 P.C.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1943</i> , to <i>March 1957</i> , that I last saw the deceased alive on <i>March 1957</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jacobs C. Evans, M.D.</i>		M.D. <i>4316-14th Street - 311 P.C.</i>		ADDRESS (Street, city or town, state) <i>Washington D.C.</i>		DATE SIGNED <i>3/1/57</i>	
22a. BURIAL, Cremation, Removal (Specify) <i>3/7/57</i>		22b. DATE THEREOF <i>3/7/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Unity-Washington Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Hurlock, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines</i>		ADDRESS <i>2901 14th St. Wash, D.C.</i>		24a. REC'D. BY REGISTRAR DATE <i>3/6/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. Gibbons</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03111

03127

CERTIFICATE OF DEATH

Reg. Dist. No. 214

TO SPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,714 St. Margaret Way		e. STREET ADDRESS 10,714 St. Margaret Way	
3. NAME OF (Type or print) WADE HAMPTON LEE		4. DATE OF DEATH March 20 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Y.M.C.A. Secretary (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Stanley County, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES LEE		14. MOTHER'S MAIDEN NAME MARY HARTSELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-6690	
17. INFORMANT		Address Mrs. Myrtle L. Mayhue, 10,714 St. Margaret Way Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1957 to April 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE JOHN S. ROGERS PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 1919 Seminary Rd., Silver Spring, Md. DATE SIGNED 2-20-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/21/57	
22c. NAME OF CEMETERY OR CREMATORIUM MILGROVE CEMETERY		22d. LOCATION (City, town, or county) (State) MIDLAND, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Warren L. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 3/26/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03128

CERTIFICATE OF DEATH

03112

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Alabama		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Alston	Last LEGG	4. DATE OF DEATH	Month March	Day 23	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4 Feb. 1901	9. AGE (In years last birthday) 56	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William LEGG				14. MOTHER'S MAIDEN NAME Katherine ALSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. 6-5-24 to 10-1-54				16. SOCIAL SECURITY NO 418-50-4892		17. INFORMANT Official Navy Records	
Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hypertension</i> <i>Arterio-Vascular Disease</i> , DUE TO <i>Male patient</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. p. m.	Month March	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arlington Nat'l Cemetery	20f. (City or town) Arlington	(County) Va.
21. I certify that I attended the deceased from 20 March , 19 57 , to 25 March , 19 57 , that I last saw the deceased alive on 25 March , 19 57 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.							
DATE SIGNED 3-26-57							
ACTUAL SIGNATURE <i>Bruce L. Canaga</i>							
PHYSICIAN'S NAME (Type) BRUCE L. CANAGA, JR. CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) Arlington, Va.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Murphy</i>				ADDRESS 1101 15th Street, N.W., Washington, D.C.			
VS A15 (4) 15M 9/55				24a. REC'D BY REGISTRAR 3-26-57			
				24b. REGISTRAR'S SIGNATURE <i>Barry E. Canally</i>			

BUREAU V.

MAR 27 1957

RECEIVED

03129

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 8110 Tahona Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8110 Tahona Dr.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Dr.	Middle Fritz	Last Levy	4. DATE OF DEATH	Month March	Day 10	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/87	9. AGE (In years from birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. William Levy		14. MOTHER'S MAIDEN NAME Anna Frankel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address Albert G. D. Levy, 1518 Flora Court, Sil. Spg., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure; myocarditis - arterio clots</i> INTERVAL BETWEEN ONSET AND DEATH several years.							
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>kyphoscoliosis (osteoarotic) & emphysema</i> 50 yrs. (c) <i>osteoporosis, hypercalcinuria</i> 20 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>ext 7</i> , 19 <i>57</i> , to <i>May 10</i> , 19 <i>57</i> that I last saw the deceased alive on <i>May 9</i> , 19 <i>57</i> , and that death occurred at <i>8 a.m.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Levyn Levy</i>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons, 3501 14th St., N. W.		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>3/13/57</i>		24b. REGISTRAR'S SIGNATURE <i>James. to the</i>	

GEAU V. S.

MAR 19 1957

GEAU V. S.

03130

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03114

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Butler and River Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John	
f. STREET ADDRESS Wilson Ave		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		First Leyking	Middle XXXXXX
4. DATE OF DEATH Month Mar	Day 11	Year 1957	Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15 1908
9. AGE (In years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic plumbing	10b. KIND OF BUSINESS OR INDUSTRY Own Business Plumbing	11. BIRTHPLACE (State or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Victor XXXXX Leyking		
14. MOTHER'S MAIDEN NAME Elizabeth Kuffner		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT (wife) Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
420.1 DUE TO Coronary Insufficiency			
sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/11/57
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/57	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn	22d. LOCATION (City, town, or county) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE 3-14-57	24b. REGISTRAR'S SIGNATURE Bruce M. Thompson

BUREAU V. S

MAR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03131 CERTIFICATE OF DEATH

03115
27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>15 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>820 Thayer Ave</i>		e. STREET ADDRESS <i>820 Thayer Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Hilda Gross</i>		First <i>Hilda</i>	Middle <i>Gross</i>
Last <i>Lockett</i>		4. DATE OF DEATH <i>March 7</i>	Month Year <i>1957</i>
5. SEX <i>Fr</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 22, 1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife - OWN HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Richard Gross</i>		14. MOTHER'S MAIDEN NAME <i>Mary Goette</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-07-3578</i>	
17. INFORMANT <i>Carrie Ashworth</i>		Address <i>820 Thayer Ave, S. 5 pg. med.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Ovary with Metastases</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
DUE TO <i>1958</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 1958</i> to <i>March 7, 1957</i> that I last saw the deceased alive on <i>March 5, 1957</i> and that death occurred at <i>3:45 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James M. Whitlock</i>		ADDRESS (Street, city or town, state) <i>7701 Carroll Ave</i>	
PHYSICIAN'S NAME (Type) <i>James M. Whitlock, M.D., Takoma Park, Md.</i>		DATE SIGNED <i>3-7-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/9/57</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Gumpkey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D. BY REGISTRAR DATE <i>3/3/57</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Jettier</i>	

BUREAU V. S.

MAR 18 1977

REGISTRY FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03132

CERTIFICATE OF DEATH

03116
216

Reg. Dist. No.

TO HOSPITAL OR
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 10 DAYS						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING						
3. NAME OF DECEASED (Type or print) JAMES		First HENRY	Middle LOHR					
4. DATE OF DEATH MARCH 13 1957	Month Day Year	5. SEX MALE						
6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1869						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY						
11. BIRTHPLACE (State or foreign country) MADISON, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME HENRY LOHR		14. MOTHER'S MAIDEN NAME MILDRED TUCKER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-26-1443 17. INFORMANT Mr. Henry W. Lahr, 3427 Tulane Drive Address Hyattsville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Liability and debility - aspiration (c) of expectorated materials		INTERVAL BETWEEN ONSET AND DEATH 2 weeks						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bladder hydrocephalus & generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hyattsville, Md.	(County) Baltimore Co.	(State) Md.
21. I certify that I attended the deceased from November 19, 1956, to April 13, 1957, that I last saw the deceased alive on April 13, 1957, and that death occurred on April 13, 1957, from the causes and on the date stated above. ACTUAL SIGNATURE JASON GEIGER		M.D.		ADDRESS (Street, city or town, state) 931 Pershing Drive, Silver Spring, Md.		DATE SIGNED 3/14/57		
22a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		22b. DATE THEREOF 3/16/57		22c. NAME OF CEMETERY OR CREMATORIUM GRAHAM CEMETERY		22d. LOCATION (City, town, or county) ORANGE, VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE Wernick & Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3-16-57		24b. REGISTRAR'S SIGNATURE Bertrand Thompson		

540 V. 2

AR 197

540 V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03039

Items 1,2 Film 3-3-57 at

03117

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Park</i>		c. LENGTH OF STAY IN 1b <i>Mar 1, 1957</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville (Langley Park)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Joseph Long</i>		First	Middle
4. DATE OF DEATH <i>March 24, 1957</i>		Last	Month
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>March 18, 1928</i>		9. AGE (In years last birthday) <i>29 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Draftsman</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		14. MOTHER'S MAIDEN NAME <i>Susan Kelly</i>	
13. FATHER'S NAME <i>Owen Long</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> YES <i>WW II Navy (579-30-3151)</i>	
16. SOCIAL SECURITY NO. <i>857-30-3151</i>		17. INFORMANT <i>Mrs. Helga Long</i>	Address <i>Same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Essential hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour D. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>217 University Blvd E</i> (County) <i>Whetton, Md.</i> (State) <i>3-24-57</i>
21. I certify that I attended the deceased from <i>May 1955</i> to <i>March 1957</i> , that I last saw the deceased alive on <i>March 24, 1957</i> , and that death occurred at <i>9:45 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard A. Fitzgerald</i>		ADDRESS (Street, city or town, state) <i>Silver Spring, Md.</i> DATE SIGNED <i>3-24-57</i>	
PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-27-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Heaven</i>
22d. LOCATION (City, town, or county) <i>Whetton, Md.</i> (State) <i>MAR 26 1957</i>		22e. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>James Long</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Hanlon, F. D., 3831 Georgia Ave., N.W., Wash. D.C.</i>		ADDRESS	DATE

BUREAU V. S.

MAR 26 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03118

03133

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 3 mos. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1619 Mount Eagle Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Miriam	Middle Eastburn	Last LOVELESS	4. DATE OF DEATH March 16 1957	Month March	Day 16	Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2 March 1904	9. AGE (in years last birthday) 53	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William K. Eastburn		14. MOTHER'S MAIDEN NAME Miriam Kirkland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Husband, Francis J. Loveless (Same As 12)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Epuedynoma, Spinal Cord		INTERVAL BETWEEN ONSET AND DEATH 2 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Nov., 1956, to 16 March, 1957, that I last saw the deceased alive on 15 March, 1957, and that death occurred at 1:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.W. Mackie, CDR, MC, USN				ADDRESS (Street, city or town, state) M.D. U.S. Naval Hospital, Bethesda, Md. 3-16-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-57		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Collins		ADDRESS 3521 14th St., N.W., Washington, D.C.		24a. REC'D BY REGISTRAR DATE 3-16-57		24b. REGISTRAR'S SIGNATURE Mary F. Cassell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S

8-14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 03134 CERTIFICATE OF DEATH

03119

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [REDACTED] Ch. ch. x.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban & 6000 Old Georgetown Rd.		d. STREET ADDRESS 4705-Hunt Ave. Ch. ch.	
3. NAME OF DECEASED (Type or print) HALLIE ETHEL Lyles		4. DATE OF DEATH March 14 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1981-10-1- 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Lyles	
14. MOTHER'S MAIDEN NAME Mary Eliza Dyer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No—Unknown) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO —		17. INFORMANT MRS Bessie Pierce (sister)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro - Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Bleeding Ulcer, Duodenal Bulb. (c)		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis Urnia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 3 14 1957, 19, that I last saw the deceased alive on 31/3/57, 19, and that death occurred at 12:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE EDWARD S. WITOWSKI JR. MD.		ADDRESS (Street, city or town, state) SUITE 400, 8218 WISCONSIN AVE.	
DATE SIGNED 14, MARYLAND.			
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 3/16/57	
22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-16-57	
		24b. REGISTRAR'S SIGNATURE Benjamin W. Thompson	

U.S. DEPARTMENT OF COMMERCE

MAR 15 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03120

CERTIFICATE OF DEATH

Reg. Dist. No.

214

03135		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]	
a. COUNTY Montgomery		b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 SILVER SPRING.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING. MD.	
3. NAME OF DECEASED (Type or print) Philip		d. STREET ADDRESS 1815 Malcolm DR	
4. DATE OF DEATH MAR. 21 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 6, 1956	
9. AGE (In years lost birthday) 0 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASH DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN J. McCARTHY		14. MOTHER'S MAIDEN NAME MARIE E. RUGGIERO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address FATHER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1956, to <u>March</u> , 1957, that I last saw the deceased alive on <u>March 11</u> , 1957, and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 920 Old Beadensburg Rd. Silver Spring, Md.	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		DATE SIGNED 3-12-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22d. LOCATION (City, town, or county) WASH DC	
23. FUNERAL DIRECTOR'S SIGNATURE L. W. Taitman		24a. REC'D BY REGISTRAR DATE APR 14 1957	
ADDRESS 11 W. Baltimore St.		24b. REGISTRAR'S SIGNATURE Lorraine P. Taitman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1914 MAR 14 1914

REVIEWED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it out the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03121
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 217
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE D.C. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Md. R-97 nr. Sunshine DOA					c. LENGTH OF STAY IN 1b 1432 Perry Place N.W.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle T.	Last McGann	4. DATE OF DEATH Mar. 16, 1957		Month	Day	Year	
5. SEX		6. COLOR OR RACE male white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1918		9. AGE (In years last birthday) 39 yrs.	10. IF UNDER 1YEAR Months 3 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk					10b. KIND OF BUSINESS OR INDUSTRY Hardware		11. BIRTHPLACE (State or foreign country) W. Va			
13. FATHER'S NAME Thomas Joseph					14. MOTHER'S MAIDEN NAME Mary Catherine Rombach					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO.		17. INFORMANT Montg Co. Police					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thoracic and Abdominal hemorrhage DUE TO sudden 23X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest & Multiple ruptures of liver DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which left highway & ran into tree										
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1:57 P.M. 3/16 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R-97		20f. (City or town) Sunshine		(County) Montg.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 3/16/57								
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION REMOVAL, (Specify) Burial		22b. DATE THEREOF 3-19-57		22c. NAME OF CEMETERY OR CREMATORIAL Macphelia Cemetery		22d. LOCATION (City, town, or county) Weston, W. Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821 14th St. N.W.		24a. REC'D BY REGISTRAR MAR 20 1957		24b. REGISTRAR'S SIGNATURE Gertude Lawless				
VS. A1SME(5) 5M 9/55										

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MAR 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03122

03137

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Beijing	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 107 Allen Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Douglas		First Middle Stewart		Last MC LEOD		4. DATE OF DEATH March 24 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 1 March 1918		9. AGE (In years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Mc LEOD				14. MOTHER'S MAIDEN NAME Florence MAC LEOD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, if unknown) Yes 6-2-41 to 9-1-56				16. SOCIAL SECURITY NO. 086-16-9750		17. INFORMANT Wife, Mrs. Hazel D. Mc Leod, (Same As #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 10A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				Multiple Myeloma		INTERVAL BETWEEN ONSET AND DEATH Appx. 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Jan., 1957, to 24 March, 1957, that I last saw the deceased alive on 24 March, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. U.S. Naval Hospital, Bethesda, Md. 3-25-57							
PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumfrey, 7627 Wisconsin Ave., Bethesda, Md.		ADDRESS R. A. Pumfrey, 7627 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-25-57		24b. REGISTRAR'S SIGNATURE Barry E. Purcell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1974

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BUREAU

03138

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,721 HOLDRIDGE ROAD				d. STREET ADDRESS 12,721 HOLDRIDGE ROAD				
3. NAME OF DECEASED (Type or print)		First IRA	Middle FRED	Last McMILLAN	4. DATE OF DEATH MARCH 14 1957	Month MARCH	Day 14	Year 1957
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8, 1899	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor - Mail Room		10b. KIND OF BUSINESS OR INDUSTRY Navy Dept U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ira Cooper McMillan				14. MOTHER'S MAIDEN NAME Mary Louise Zypphrech				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW # 1		17. INFORMANT Mrs. Robert J. Kilby, 20 W. Custis Ave. Alexandria, Virginia				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 3/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/57	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Warren L. Humphrey,		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE 3/19/57		24b. REGISTRAR'S SIGNATURE Frances Potts			

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

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MAR 21 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03124

03139

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Montgomery		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 10002 Frederick Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Allison		First B	Middle McQuin	Last March	4. DATE OF DEATH Month 27	Day 19	Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 3/18/1888	9. AGE (In years lost birthday) yrs. 69	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 9	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office, Ret.		10b. KIND OF BUSINESS OR INDUSTRY mail carrier		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Byron McQuin				14. MOTHER'S MAIDEN NAME Catherine Jensen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Catherine Tracey, 10004 Fred. Ave. Kens.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 141X DUE TO Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Pulmonary edema (c) Carcinoma of tongue					INTERVAL BETWEEN ONSET AND DEATH 24 hours			
					45 hours			
					8-12 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 26, 1957 to March 27, 1957 , that I last saw the deceased alive on March 26, 1957 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Thomas A.N. Hindman				ADDRESS (Street, city or town, state) M.D. 3935 Baltimore St		DATE SIGNED 3/27/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/1957		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-28-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03040

03125

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Montgomery		Maryland	
b. C. TTY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB 6 mo.	
Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, MD	
d. NAME OF HOSPITAL (If not in hospital, give street address) (Private OR INSTITUTION)		d. STREET ADDRESS 16905 East Ave	
7711 Garland Ave home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH March 24 1957	
First Fredericka		Middle Dorothea	
Last Meininger		Month Year	
5. SEX Fe	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Rosendale		14. MOTHER'S MAIDEN NAME Dorothea Sellner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Meininger		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 1956, to <u>March 24</u> , 1957, that I last saw the deceased alive on <u>March 24</u> , 1957, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE James M. Whitlock PHYSICIAN'S NAME (Type) James M. Whitlock		ADDRESS (Street, city or town, state) 7701 Carroll Ave Takoma Park, Md. DATE SIGNED 3-24-57	
22a. BURIAL, CREMATION — REMOVAL <input type="checkbox"/> 3/26/57		22b. DATE THEREOF 3/26/57	
22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 3/26/57	
ADDRESS Wash, DC		24b. REGISTRAR'S SIGNATURE William E. Hines	

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MAR 27 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03126

03140

CERTIFICATE OF DEATH

Reg. Dist. No. **XXX** 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27, 16826		d. STREET ADDRESS 6307 Foot Street, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First Howard Middle Blaine Last Miller, Sr.		4. DATE OF DEATH March 11 1957		Month March Day 11 Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 2 Sept. 1884		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Miller				14. MOTHER'S MAIDEN NAME Sara Duvan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 5p. American War Unknown		17. INFORMANT (son) Howard B. Miller, Jr. (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic Carcinoma of liver				INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Probably 2^o to CARCINOMA of lung (had liver left lung resection 2 yrs ago for carcinoma)				2 + yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 March 1957 to 11 March 1957 , that I last saw the deceased alive on 11 March 1957 , and that death occurred at 11:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-11-57							
ACTUAL SIGNATURE Wm B. Ingram							
PHYSICIAN'S NAME (Type) Wm. B. INGRAM, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS, 517 11th St., S.E. Washington, D. C.				ADDRESS		24a. REC'D BY REGISTRAR DATE 3-11-57	
						24b. REGISTRAR'S SIGNATURE Bruce E. Russell	

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MAR 15 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1

may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03141

CERTIFICATE OF DEATH

031274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 or 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) JOSEPH DAVIS MILLER		d. STREET ADDRESS R. #2, COLUMBIA PIKE	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
4. SEX MALE	5. COLOR OR RACE WHITE	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH OCT. 9, 1877	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (owner) retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Montgomery County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS YOST MILLER		14. MOTHER'S MAIDEN NAME ANNIE ELIZABETH LINDSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Walter Y. Miller, R. #2, Columbia Pike Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 13 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson Disease, - about 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 11, 1957</u> to <u>Nov 24, 1957</u> that I last saw the deceased alive on <u>Nov 24, 1957</u> , and that death occurred <u>01:45 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) SILVER SPRING, MD. 20910 DATE SIGNED 3-25-57	
ACTUAL SIGNATURE JOHN S. ROGERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/27/57	
22c. NAME OF CEMETERY OR CREMATORIAL COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Werner G. Humphrey,		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 3/27/57		24b. REGISTRAR'S SIGNATURE James Walter	

RECEIVED
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MAR 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03142

CERTIFICATE OF DEATH

Reg. Dist. No. 03128
 276

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, -Washington 16, D. C.		d. STREET ADDRESS 4633 River Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4633 River Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edna		First A	Middle Mohagen	Lost	4. DATE OF DEATH March 1	Month XXX	Day 19	Year 57	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/27/1905	9. AGE (in years last birthday) 51	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Histopathologicne Tech. Dept. of Agr.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Grafton, N. Dakota		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Christion Mehagen				14. MOTHER'S MAIDEN NAME Elise Wanlof					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Verna C. Mohagen, 4633 River Rd. Beth.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Neomia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>wide spread metastasis of</i>						<i>1/2 year</i>			
(c) DUE TO <i>Carcinoma, throat</i>						<i>1/4 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4861 Battery Lane		20f. (City or town) Bethesda, Md.		(County) Bethesda, Md.	(State) Md.
21. I certify that I attended the deceased from 2/28 , 19 57 , to 3/1 , 19 57 , that I last saw the deceased alive on 3/1 , 19 57 , and that death occurred at 1130 M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 4861 Battery Lane	DATE SIGNED Bethesda, Md.
ACTUAL SIGNATURE <i>Charles J. Savarese, Jr.</i>									
PHYSICIAN'S NAME (Type) Charles J. Savarese, Jr.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 3-5-57		22c. NAME OF CEMETERY OR CREMATORIUM Grafton Lutheran Cem.		22d. LOCATION (City, town, or county) Walsh County, No. Dakota.		(State) No. Dakota.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS 8-2-57		24a. REC'D BY REGISTRAR Business Thompson		24b. REGISTRAR'S SIGNATURE Business Thompson			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03143 CERTIFICATE OF DEATH

03129
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 7 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Florida		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daytona Beach		d. STREET ADDRESS 312 Sears Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edith	Middle Myrl	Lost	4. DATE OF DEATH	Month March	Day 25	Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1896	9. AGE (In years lost birthday) 60 yrs	F UNDER 1 YEAR Months 60	F UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Glover L. Gough			14. MOTHER'S MAIDEN NAME Nannie K. Bowling						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, give war or dates of service) No		16. SOCIAL SECURITY NO 577-01-4091		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cancer of the heart (c)</p> <p>Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>INTERVAL BETWEEN ONSET AND DEATH <i>age - 19 1/2 living 2 1/2</i> <i>23 days</i></p>									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Daytona Beach		(County) Fla	(State) Fla
<p>21. I certify that I attended the deceased from March 18, 19 57 to March 25, 19 57, that I last saw the deceased alive on March 25, 19 57, and that death occurred at 6:05 P.M. from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <i>David G. Nathan</i> MD</p> <p>PHYSICIAN'S NAME (Type) David G. Nathan, M. D.</p> <p>ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland</p> <p>DATE SIGNED 3/25/57</p>									
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/57		22c. NAME OF CEMETERY OR CREMATORIUM Belview		22d. LOCATION (City, town or county) (State) Daytona Beach, Fla			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Wash, D.C.		24a. REC'D. BY REGISTRAR DATE MAR 27 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03130

03144

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived. If institutional, Residence before admission] a. STATE New York	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 467 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] New York City	
3. NAME OF DECEASED (Type or print) Miss Helen		First Teresa	Middle Montgomery
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH September 9, 1882	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) yrs 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
10c. BIRTHPLACE (State or foreign country) Scotland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Montgomery		14. MOTHER'S MAIDEN NAME Ellen McArdle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) No		16. SOCIAL SECURITY NO 17. INFORMANT The Medical Record Address Not Available The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) CARCINOMA BREAST WITH METASTASES DUE TO (c) DIVERTICULITIS OF COLON		INTERVAL BETWEEN ONSET AND DEATH 8 1/2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SURGICAL HYPOPHYSECTOMY		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 21, 1955 to March 2, 1957 that I last saw the deceased alive on March 2, 1957 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Samuel Charache</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 3/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans.		22b. DATE THEREOF 3/5/57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Chester, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-5-57	
		24b. REGISTRAR'S SIGNATURE Bennie M. Fink	

PEAU V. E
MAR 7 1957
LAWRENCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03131

03145

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 750 Barnaby Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Michael	Middle Timothy	Last MULCAHY	4. DATE OF DEATH Month March	Day Year 24 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 March 1957	9. AGE (In years last birthday) yrs 4	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS Hours 0	Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John J. MULCAHY			14. MOTHER'S MAIDEN NAME Josephine Marie Pugh					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (Father) John J. MULCAHY (Same As #2)		Address		
No		None						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis						INTERVAL BETWEEN ONSET AND DEATH 70 hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 20 March , 1957, to 24 March , 1957, that I last saw the deceased alive on 24 March , 1957, and that death occurred at 10:35 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED Daniel Shuptar								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Daniel Shuptar M.D. U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				ADDRESS 15M 9/55		24a. REC'D BY REGISTRAR DATE 3-25-57		
24b. REGISTRAR'S SIGNATURE Betty E. Passelly								

ALBERT V. S.

AR 66 1957

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03132

03146

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 21 mos. 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 412-4		d. STREET ADDRESS 4205 Wisconsin Ave. N. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS 4205 Wisconsin Ave. N. W.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Rose		First	Middle	Last	4. DATE OF DEATH J. R. 11 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH J. R. 15, 1914	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Patrick O'Hagan		14. MOTHER'S MAIDEN NAME Alice Stuart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Mr. Gilbert McInerny		Address Pt. 2, Grill Avenue		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Respiratory Failure Arterosclerosis & Cerebral Thrombosis associated & Cancer of the Esophagus; & metastasis.		INTERVAL BETWEEN ONSET AND DEATH From 10 to March 11/1957		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mt. Olivet Cemetery		20f. (City or town) Washington		(County) (State)
21. I certify that I attended the deceased from October 1957 to March 11, 1957, that I last saw the deceased alive on 3-10-1957, and that death occurred at 1835 Eye St. N.W. M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 1835 Eye St. N.W.		DATE SIGNED
ACTUAL SIGNATURE Richard J. Meyer M.D.								
PHYSICIAN'S NAME (Type) Richard J. Meyer						WASH 6, D.C.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/57		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington		(State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bawden		ADDRESS 1756 Penna Ave. N.W.		24a. REC'D BY REGISTRAR DATE 3-14-57		24b. REGISTRAR'S SIGNATURE Bennie McPherson		

RECEIVED

MAR 18 1957

4:12 V

BUREAU V. A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03147 CERTIFICATE OF DEATH

Reg. Dist. No. 216
03133

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 2002 August Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Helen	Middle Muriel	Last Oliver	4. DATE OF DEATH	Month March	Day 31, 1957	Year
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH February 25, 1904	9 AGE (In years last birthday) 53	F UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary CLERK		10b KIND OF BUSINESS OR INDUSTRY CIBA DRUG CO. Unascertainable		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Hyer		14. MOTHER'S MAIDEN NAME Ellen Cooney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>multiple thrombocytopanic hemorrhage + pancytopenia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>phosphorous 32 intoxication</u> 4 weeks							
DUE TO							
(c) <u>metastatic breast cancer</u> 3 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1957</u> to <u>March 31, 1957</u> , that I last saw the deceased alive on <u>March 31, 1957</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William J. Pieper</u>		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 4/3/57		22b. DATE THEREOF 4/3/57		22c. NAME OF CEMETERY OR CREMATORIUM ST. RAYMOND CEMETERY		22d. LOCATION (City, town, or county) NEW YORK CITY, NEW YORK (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren S. Humphrey</u>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-3-57		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03041 **CERTIFICATE OF DEATH**

03134

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b II hrs. 55mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS Rt. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emma		First Emma	Middle (MM)	Last Olsen	4. DATE OF DEATH March 26 1957	Month March	Day 26	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-81	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? America
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Norway				
13. FATHER'S NAME Ole Olsen		14. MOTHER'S MAIDEN NAME Karen Mortensen						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 1 day		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 860.8		(b) DUE TO Smoking cigarette + Hypertension				5-10 yrs		
(c) American diet + age								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes Mellitus						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7401 13L AIR		20f. (City or town) Chicago	(County) Illinois	(State)
21. I certify that I attended the deceased from alive on 3/26/57 , 19 57 , to 3/26/57 , 19 57 , that I last saw the deceased and that death occurred at 3:55 M, from the causes and on the date stated above. ACTUAL SIGNATURE Chas. H. Wilson M.D.						ADDRESS (Street, city or town, state) 7401 13L AIR		
PHYSICIAN'S NAME (Type) Chas. H. Wilson						DATE SIGNED 3/26/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 3/30/57		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive		22d. LOCATION (City, town, or county) Chicago		(State) Illinois
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS 7557 Mass. Ave. Bldg.		24a. REC'D. BY REGISTRAR 3/27/57		24b. REGISTRAR'S SIGNATURE John Redd		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU N.Y.

MAR 3 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03148

CERTIFICATE OF DEATH

Reg. Dist. No.

03135

217

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Md.		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Bethesda		c. LENGTH OF STAY IN 1b 45 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase 15					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1911 Dorset Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Char	Middle cc	Last John	4. DATE OF DEATH Mar 13	Month Mar	Day 13	Year 1957		
5. SEX M 16	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1er 1884	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Building & Print.		11. BIRTHPLACE (State or foreign country) Phil del his, P.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John E. O'Neile			14. MOTHER'S MAIDEN NAME Unknown			Address Same as 2			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT Lorraine B. O'Neile		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
						cardi ^o vascular disease		3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) MD 1820 Biltmore St 11th		(County) Washington, D.C.	(State) D.C.
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Mar 23, 1957</u> that I last saw the deceased alive on <u>Feb 21, 1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 1820 Biltmore St 11th Washington, D.C.	DATE SIGNED
ACTUAL SIGNATURE E. E. Quayle									
PHYSICIAN'S NAME (Type) E. E. Quayle									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill		22d. LOCATION (City, town, or county) Washington, D.C.		(State)	
23a. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR DATE 26 1957		24b. REGISTRAR'S SIGNATURE Beau Thompson			

RECEIVED

BUREAU V. S.

MAR 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03136

03149

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS 11 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sharen		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/57	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME AMOS Landers Pearson		14. MOTHER'S MAIDEN NAME Frances Marie Sheeler						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Record		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Heart Failure				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any.		(b) DUE TO A Tectasis				3 days		
		(c) DUE TO Prematurity						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 10, 1957</u> to <u>March 13, 1957</u> that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE LUCILLE R. LEAL		ADDRESS (Street, city or town, state) 108 N. Frederick Ave. Gaithersburg, Md.						
PHYSICIAN'S NAME (Type) L. I. Leal, M. D.		DATE SIGNED 3/14/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Forest Park		22b. DATE THEREOF 7-10-57		22c. NAME OF CEMETERY OR CREMATORIAL Forest Park		22d. LOCATION (City, town, or county) Gaithersburg		
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Partner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE 3-15-57 24b. REGISTRAR'S SIGNATURE Esther B. Lawley						

RECEIVED

MAR 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be reigned by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 03150

03137

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY IN 1b 10 hours		d. STREET ADDRESS Rt. #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Erwin	First Lee	Last Phelps	4. DATE OF DEATH March 11 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY + Blawkrsmith	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Phelps		14. MOTHER'S MAIDEN NAME Rose Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 'O X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSETS AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchitis, Colds		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		3/10 1957 to 3/11 1957, that I last saw the deceased and that death occurred at 11:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE	M.D.		
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.	Sandy Spring, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 13	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel	22d. LOCATION (City, town, or county) Unity (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bogie W. Barker	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE 9-13-57	24b. REGISTRAR'S SIGNATURE Estherde B. Lawry

RECEIVED
MAR 21 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03138

03042

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. Takoma Park		b. COUNTY Md. Takoma Park			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 9021 Flower Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Martha	Middle Alice	Last Reel	4. DATE OF DEATH March 11	Month March	Day 11	Year 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-85		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired)		Retired Cashier		Penns		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Marx		14. MOTHER'S MAIDEN NAME Sarah Kerr							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		DUE TO (b) DUE TO (c)		Uremic poisoning Obstruction of ureters-bilat. Carcinoma of Bladder-recent		INTERVAL BETWEEN ONSET AND DEATH 10 days 6 mo 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Jan. 15, 1957</u> to <u>March 10, 1957</u> , that I last saw the deceased alive on <u>March 9, 1957</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE John F. Brownberger, M.D.				ADDRESS (Street, city or town, state) 2600 Carroll Ave - Mar. 11 '57		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 13, 1957		22c. NAME OF CEMETERY OR CREMATORIUM George Washington Cemetery		22d. LOCATION (City, town, or county) Prince George County, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Tedder		ADDRESS 254 Carroll St. - 8th		24a. REG'D. BY REGISTRAR DATE 3/13/57		24b. REGISTRAR'S SIGNATURE John Keith			

BUREAU V. S.

1948 - 1977

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

03043 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03139-223
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 5 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sligo- 7th Day Adventist Church		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
3. NAME OF DECEASED (Type or print) John A. Pierson		4. DATE OF DEATH Mar. 16, 1957	Month Day Year 1957 16 19		
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1875		
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter	11. BIRTHPLACE (State or foreign country) Mass.		
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Not Available			
14. MOTHER'S MAIDEN NAME Not Available		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 17. INFORMANT		Address Mrs. Munson Cook, Ogdensburg, New Jersey			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) Coronary occlusion					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? NO					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar. 16, 1957		
EXAMINER'S NAME (Type) Frank J. Broschart	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Mar. 20, 1957	22c. NAME OF CEMETERY OR CREMATORIAL HARISON CEMETERY	22d. LOCATION (City, town, or county) NORTH CHURCH, NEW JERSEY	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Waites, 254 Carroll St NW HC</i>	ADDRESS <i>J. Arthur Waites, 254 Carroll St NW HC</i>	24a. REC'D BY REGISTRAR DATE 3/18/57	24b. REGISTRAR'S SIGNATURE <i>J. Arthur Waites</i>		

DUBEAU V. S.

MAR 12 1968

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-tranish permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 03:51 CERTIFICATE OF DEATH

03140
 214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY TUCKER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8207 GEORGIA AVENUE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARSONS	
3. NAME OF DECEASED (Type or print)		First Maude	Middle Alice
Last Plum		4. DATE OF DEATH MARCH 21 1957	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME SAMUEL SHAFFER		14. MOTHER'S MAIDEN NAME ANGELINE (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) NO		16. SOCIAL SECURITY NO none	
17. INFORMANT Mr. J. Willard Plum, 8207 Georgia Ave. Silver Spring, Maryland		Address INTERVAL BETWEEN ONSET AND DEATH 5 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Heart Disease & Hypertension (c)		5 yrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Glomerulonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1954, to 31 March 1957, that I last saw the deceased alive on 20 March 1957, and that death occurred at 7:50 AM, from the causes and on the date stated above. ACTUAL SIGNATURE: Russell B. Arnold M.D. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D. ADDRESS (Street, city or town, state): 8801 Colesville Road, DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/23/57	
22c. NAME OF CEMETERY OR CREMATORIUM CITY CEMETERY		22d. LOCATION (City, town, or county) PARSONS, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Lumpkin, SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/26/57	24b. REGISTRAR'S SIGNATURE Frances Coffin

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APR 3 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03152

031416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN, Md.				c. LENGTH OF STAY IN 1b 11/1/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GORDON MAURICE PLUMMER				4. DATE OF DEATH MARCH 4 1957			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 MAY 1941	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GARNETT AUGUSTUS PLUMMER				14. MOTHER'S MAIDEN NAME HANNAH ELEANOR HOES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT FATHER				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OSTEOPENIC SARCOMA, GENERALIZED METASTESIS 20 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OSTEOPENIC SARCOMA, PRIMARY RIGHT FEMUR 20 months DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1/57 to 1/1/57 , that I last saw the deceased alive on 1 MARCH 1957 , and that death occurred at 10:20 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert M. Dimmette M.D. ADDRESS (Street, city or town, state) 9710 BRIXTON LANE, Bethesda, Md. 20814 DATE SIGNED 1/1/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/7/57		22c. NAME OF CEMETERY OR CREMATORIAL St. Rose		22d. LOCATION (City, town, or county) (State) Cloppers, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.			
24a. REC'D BY REGISTRAR 1/1/57				24b. REGISTRAR'S SIGNATURE Alfreda Cooke			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 11 1957

CONFIDENTIAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifier, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03142

Reg. Dist. No. 212.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Montgomery		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Dickerson		Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Elmer School + Clark Hollow Rd			
3. NAME OF DECEASED (Type or print)		First	Middle
John		Ethan	Poole
4. DATE OF DEATH		Month	Day
May 27		1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2-15-97
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
60 yrs		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
farmer-Crones-Retired		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		md	
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME	
Elgin Poole		Raymond Poole (Son) Poolsville Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	
		Coronary occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED	
Frank J. Brossart		3-27-57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial 3/30/57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
		22d. LOCATION (City, town, or county) (Sign)	
		Beallsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
William B. Wilson Barnesville Md		24b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03154 CERTIFICATE OF DEATH

03143

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #1, Box 25	
3. NAME OF DECEASED (Type or print) Ted		First Edward	Middle Poole, Jr.
4. DATE OF DEATH March 25,		Month March	Day 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH October 20, 1956		9. AGE (In years last birthday) yrs 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ted Edward Poole, Sr.	
14. MOTHER'S MAIDEN NAME Margaret Dillard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	
16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) acute myocardial infarction		Cerebral hemorrhage acute myocardial infarction	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1957, to March 25, 1957, that I last saw the deceased alive on March 25, 1957, and that death occurred at 3:10 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state)		DATE SIGNED 3/25/57	
ACTUAL SIGNATURE Gurston Goldin, M. D. NAME (Type)		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 3/26/57	22c. NAME OF CEMETERY OR CREMATORIUM Greenwood
22d. LOCATION (City, town, or county) Gaston Co., N. Carolina		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-28-57	24b. REGISTRAR'S SIGNATURE Bessie M. Wong, R.N.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03144

03155

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. II institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b RURAL and give nearest town Kensington-Rock Creek Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9812 E. Bexhill Drive		d. STREET ADDRESS 9812 E. Bexhill Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fenner	Middle D.	Last POWELL
4. DATE OF DEATH	Month March	Day 2	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1890
9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 13	12. IF UNDER 24 HRS Hours 10 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Self-employed Real Estate	
10c. BIRTHPLACE (State or foreign country) Kenton, Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Parnell		14. MOTHER'S MAIDEN NAME Alice McKelvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W. W. I		16. SOCIAL SECURITY NO. 579-07-9210	
17. INFORMANT Lucy Powell-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
(b) Advanced coronary sclerosis		6 mos. +	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1950, to _____, 1957, that I last saw the deceased alive on _____, and that death occurred at 10:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 3921 Ingomar St. N. W. Wash. D. C. 3/2/57 DATE SIGNED			
ACTUAL SIGNATURE <i>Stewart Clapp</i>		PHYSICIAN'S NAME (Type) Stewart Clapp, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 3-2-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 To be retained by the Hospital or attending Physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03145

03156

CERTIFICATE OF DEATH

Reg. Dist. No 10

1. PLACE OF DEATH ■ COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		a. STATE Maryland b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6309 Tone Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 6309 Tone Dr., Beth., Md.	
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	Last	4. DATE OF DEATH Month March Day 11, 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/83	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary	
13. FATHER'S NAME Josef Robitsek		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address Benjamin A. Theeman, 6309 Tone Dr., Beth., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Nephatic failure		INTERVAL BETWEEN ONSET AND DEATH 2 months	
19.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		Metastatic adenocarcinoma, primary site unknown.			
DUE TO (c)		None			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1952, to March 11, 1952, that I last saw the deceased alive on March 11, 1952, and that death occurred at 3:00 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Eugene S. Gladseen		ADDRESS (Street, city or town, state) M.D. 901 20th St. N.W.		DATE SIGNED 3-11-52	
PHYSICIAN'S NAME (Type) EUGENE S. GLADSEEN		Wash., D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/57		22c. NAME OF CEMETERY OR CREMATORIUM Beth Olom Cemetery	
22d. LOCATION (City, town, or county) Queens, L. I., New York		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons, 3501 14th St., N.W.		ADDRESS Wash., D.C. ADDRESS Wash., D.C.		24a. REC'D BY REGISTRAR DATE 3-13-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

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BUREAU X.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03146

03041 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		11 Nicholson St. NW b. COUNT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville Md.	11 da	Rock. D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Frech. San & Hosp.	11 Nicholson St. NW		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
Moses			Lost Month Day Year Mar 21 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	W-blk	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 30, 1884
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) 72 yrs	
Musician		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?	
Russia		American	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benjamin Ratner		Severa ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) Nat		16. SOCIAL SECURITY NO. 17. INFORMANT 577-24-4056 Mael. San & Hosp. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address	
myocardial failure - acute 1-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) Anteriosclerotic Heart Disease		f. 1957	
(c) Generalized arteriosclerosis		Long duration	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Bronchial asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/21/1957 to March 21, 1957, that I last saw the deceased alive on 3/21/1957, and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Benjamin Ratner		M.D. 2233 Alabama Ave. N.W. N.H. 12, D.C.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1957	
22c. NAME OF CEMETERY OR CREMATORI Crescentgrad Cem.		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Loebberg Funeral Home		24a. REC'D BY REGISTRAR DATE 3/23/57	
		24b. REGISTRAR'S SIGNATURE F. Nelson Proctor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03157 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03147

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL Cabin John)		c. LENGTH OF STAY IN 1b		b. STATE Maryland b. COUNTY Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7707 MacArthur Blvd.		d. STREET ADDRESS 7707 MacArthur Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PERCY		First	Middle	Last	4. DATE OF DEATH Fax March 4, 1957		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 4, 1890	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 10 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Ch. Quarterman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Cropley, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thomas Redden		14. MOTHER'S MAIDEN NAME Isabelle Pennifield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Isabelle L. Redden-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden							
40.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE	Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3/4/57		
EXAMINER'S NAME (Type)	Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/1957	22c. NAME OF CEMETERY OR CREMATORIAL Parklawn		22d. LOCATION (City, town, or county) Montgomery	(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-5-57	24b. REGISTRAR'S SIGNATURE Bevrie M. Thompson		

BUREAU V. S

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LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03148
Reg. Dist. No. 21

03:58			
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 51 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			
3. NAME OF DECEASED (Type or print)	First Dorothy	M dd'e Mae	4. DATE OF DEATH Reeder
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legislative Researcher		10b. KIND OF BUSINESS OR INDUSTRY Library of Congress	
10c. BIRTHPLACE (State or foreign country) Pennsylvania		11. AGE (In years from birthday) 54 yrs	
13. FATHER'S NAME Samuel Reeder		14. MOTHER'S MAIDEN NAME Lillian Lingo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) No		16. SOCIAL SECURITY NO. 262-54-9922	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0		DUE TO Hepatic Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cirrhosis		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland (County) Md. (State)	
21. I certify that I attended the deceased from January 23, 1957 to March 15, 1957 , that I last saw the deceased alive on March 15, 1957 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Wolff		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3-18-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Sedgar Hill Crematory		22d. LOCATION (City, town or county) Suitland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gavrilis Sons 1756 Pa Ave. N.W.		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR DATE 3-18-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

REC'D MAR 21 1957

BUREAU V.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03149

03159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
3. NAME OF DECEASED (Type or print) <i>RAYMOND FREDRICK REMLER</i>		d. STREET ADDRESS <i>5204 - Murray Rd.</i>	
4. DATE OF DEATH <i>MARCH 14 1957</i>		Month	Day
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1898 April 15</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>T.I.E.</i>	
10c. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HENRY REMLER</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Schaubaut</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>1930</i>	
17. INFORMANT <i>Ethel REMLER - phone</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL EMBOLUS</i> DUE TO <i>400.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>AURICULAR FIBRILLATION</i> <i>ARTERIOSCLEROTIC HEART DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CIRRHOSIS OF LIVER</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 1957</i> to <i>March 14, 1957</i> , that I last saw the deceased alive on <i>March 14, 1957</i> , and that death occurred at <i>13:15 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Morton C Creditor</i> M.D. <i>WASHINGTON CLINIC</i> ADDRESS (Street, city or town, state) <i>Washington 15-1 C.</i> DATE SIGNED <i>3/14/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit 3/16/57</i>		22b. DATE THEREOF <i>3/16/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Grandview</i>		22d. LOCAT ON (City, town, or county) (State) <i>Beaver Falls, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>3-16-57</i>		24b. REGISTRAR'S SIGNATURE <i>Beaure M. Thompson</i>	

PEAU V. S.

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JOEL A. ELLIOTT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03160

CERTIFICATE OF DEATH

Reg. Dist. No. 217

103150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, MD</i>		c. LENGTH OF STAY IN 1b <i>4 years 4 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Luther Burbank Home Foundation</i>		e. STREET ADDRESS <i>305 195 Chevy Rd</i>	
f. NAME OF DECEASED (Type or print) <i>William</i>		First <i>Howard</i>	Middle <i>Harrison</i>
g. LAST <i>Harrison</i>		4. DATE OF DEATH <i>7/16/57</i>	Month Day Year <i>July 16 1957</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>WIDOWED</i> <input type="checkbox"/> DIVORCED <i>May 13 1874</i>
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief Clerk - rate Dept. Southern RR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Southern RR</i>	
11. BIRTHPLACE (State or foreign country) <i>Conn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Howard Rieger</i>		14. MOTHER'S MAIDEN NAME <i>Lilie Daniels</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W. 95-5 Rieger 12-602-0116</i>	
17. INFORMANT <i>Mrs. Ruth Rieger</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>351X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterio Sclerotic</i> (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>Paroxysm</i>	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Bethesda, MD</i>	
21. I certify that I attended the deceased from <i>7/16/57</i> , 19 <i>57</i> , to <i>7/16/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7/16/57</i> , 19 <i>57</i> , and that death occurred at <i>9:25 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. W. Bird</i>		22. ADDRESS (Street, city or town, state) <i>Bethesda, MD</i>	
23. PHYSICIAN'S NAME (Type) <i>J. W. BIRD</i>		24. DATE SIGNED <i>7/16/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/18/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>NORLAND CEMETERY</i>		22d. LOCATION (City, town, or county) <i>CHAMBERSBURG, PENNSYLVANIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter S. Humphrey</i>		24a. REC'D BY REGISTRAR DATE <i>9-16-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Gertrude B. Lawler</i>			

BUREAU V. E.

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03151

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE	
Montgomery Maryland		Md. Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 7 weeks	
Ridgemoor Park		1200 Woodside Pkwy, Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1200 Woodside Pkwy	
Cedar Haven Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Margaret Jane Riggan		Lost	4. DATE OF DEATH Month Day Year March 25 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Fe		Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2/11/1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country)
Housewife		Own home	Maryland
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME	
Dave Evans		Mary E. Sears Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT	
		1200 Woodside Pkwy Mary Sears G. Evans (niece) Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		9 days	
400.1 DUE TO Myocardial Infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Carcinoma of neck - 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 27</u> , 1957 to <u>March 25</u> , 1957 that I last saw the deceased alive on <u>March 25</u> , 1957, and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7201 Carroll Ave</u> DATE SIGNED <u>3/27/57</u>	
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/57	
22c. NAME OF CEMETERY OR CREMATORIUM RIGGIN CEMETERY		22d. LOCATION (City, town, or county) CRISFIELD, MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren & Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
		24a. REC'D BY REGISTRAR DATE <u>3/27/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>John R. D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REF ID: A6425

MAR 20 1973

PREEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03152

03161

CERTIFICATE OF DEATH

Reg. Dist. No. d/6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 4504 Franklin St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4504 Franklin St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude		First L.	Middle Rollins	4. DATE OF DEATH March 15 1957	Month March	Day 15	Year 1957
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2-1884	9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Eagleston		14. MOTHER'S MAIDEN NAME Katherine Glick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT William L. Rollins		Address 2522 Glenwood Park New Albany, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Cerebral Vascular Hemorrhage, cerebral Malignant hypertension							
INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/21, 1957, to 3/15, 1957, that I last saw the deceased alive on 3/15/57, 1957, and that death occurred at 4:50 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE I. L. Marks						ADDRESS (Street, city or town, state) M.D. 6306 Wisconsin Ave	
22d. BURIAL, CREMATION, CEMETERY (Specify) Burial		22e. DATE THEREOF 3/18/57		22f. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22g. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 3-18-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

REAU V. S.

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REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03162

CERTIFICATE OF DEATH

03153

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Bethesda		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4410 Montgomery Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4410 Montgomery Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ernest		First	Middle	Last	4. DATE OF DEATH 3	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/1900	9. AGE (In years lost birthday) 56 yrs	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Days 20	12. IF UNDER 24 HRS Hours 0
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Architect		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wm. A. Rosengarth		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Not applicable		17. INFORMANT Wife		Address Above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1608 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO c.		Carcinoma of Lung				INTERVAL BETWEEN ONSET AND DEATH 7 mo.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 1956, to March 27, 1957, that I last saw the deceased alive on April 23, 1957, and that death occurred at 258 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE ROBERT R. MONTGOMERY M.D.		ADDRESS (Street, city or town, state) 1746 K ST. N.W. 3/27/57						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Bur-Transit 3/29/57		22b. DATE THEREOF 3/29/57		22c. NAME OF CEMETERY OR CREMATORIAL Louis Wills Burial Gr.		22d. LOCATION (City, town, or county) Gretna (State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, 7557 Wisc. Ave. Beth.		ADDRESS Maryland		24a. REC'D BY REGISTRAR DATE 8-28-57		24b. REGISTRAR'S SIGNATURE Benji M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03163

113154

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 26 hrs.	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Pauline	Middle Rothman	Month 3
4. DATE OF DEATH Year 1951	Day 21		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12 1878 7879 yrs
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if not rec'd.) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Music	
10c. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAZAR FELTZER		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT (Son) MR. BERNARD Rothman, 8107 Garland Ave., Takoma Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Coronary Atherosclerosis (c) DUE TO Generalized Atherosclerosis		Address 8107 Garland Ave., Takoma Park, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paralytic Ileus - cerebral Atherosclerosis - Old Septoaneurysm		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Yes <input type="checkbox"/> No <input type="checkbox"/>	
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-25-51 to 3-21-51, that I last saw the deceased alive on 3-20-51, and that death occurred at 12 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Geo. A. Gray, M.D.	PHYSICIAN'S NAME (Type) Geo. A. Gray, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/24/51	22c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden, Falls Church, Va.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE B. Nanyandy & Sons - 3501 14th St. N.W.		ADDRESS 3. Nanyandy & Sons - 3501 14th St. N.W.	24a. REC'D BY REGISTRAR DATE 3-26-51
			24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

RECEIVED
BUREAU V. A.

MAR 09 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03045

CERTIFICATE OF DEATH

03155

Reg. Dist. No. 293

Hospital or attending physician: _____
 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-form. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>29 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7408 BALTIMORE AVENUE</i>		d. STREET ADDRESS <i>7408 Bolton Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Margaret ANN</i>		First	Middle	Last	4. DATE OF DEATH <i>March 3 1957</i>	Month	Day	Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/25/88</i>		9. AGE (In years last birthday) <i>68 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Christian Schneider</i>		14. MOTHER'S MAIDEN NAME <i>Fredricka Schulta</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>none</i>		
17. INFORMANT <i>Mr. Joseph J. Rowan, 7408 Baltimore Ave.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral vascular accident</i>		Address <i>Takoma Park, Maryland</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>		
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</i>		(b) DUE TO <i>cerebral arteriosclerosis</i>	DUE TO <i>generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Oct 3 1947</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7852 16th & 4th</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ <i>Oct 3, 1947</i> to <i>March 3, 1957</i> , that I last saw the deceased alive on <i>March 3, 1957</i> , and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. E. Kreuzburg</i>		ADDRESS (Street, city or town, state) <i>Washington, D.C.</i>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/7/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. OLIVE CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Humphrey</i>		ADDRESS <i>STIN & SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>3/6/57</i>		24b. REGISTRAR'S SIGNATURE <i>John D. Dill</i>		

ПУСКАУ В. С.
1987 г.
ПУСКАУ В.

ITEM 08047 214 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Reg. Dist. No. 773
 03156

1. PLACE OF DEATH
 a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
 a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park RURAL

c. LENGTH OF STAY IN 1b

48 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium Hospital

3. NAME OF
 -DECEASED
 (Type or print) Kathryn

First

Middle

Isobel

Last

Rupp

4. DATE
 OF
 DEATH

Month

Day

Year

3 - 31 -

1957

5. SEX

Female

6. COLOR OR RACE

Cauc

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Baumgardner

14. MOTHER'S MAIDEN NAME

Margaret Sinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

217-10-0003

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

917.0

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause lost.

DUE TO

(b)

2nd & 3rd degree burns, Accidental

DUE TO

(c)

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY

PERFORMED?

YES NO

20a. MEDICAL CERTIFICATION

20b. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

Hour

4:30 p.m.

3-29

1957

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Bel Air, Maryland

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that

death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

FRANK J. Bloschait

22a. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-1-57

22b. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22c. DATE THEREOF

4-3-57

22d. NAME OF CEMETERY OR CEMINATORY

Mt. Olivet Cemetery

22e. LOCATION (City, town, or county)

Frederick - Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

C E Cline. Jr. & Sons

Frederick Md.

ADDRESS

DATE 3 April 1957

REC'D BY REGISTRAR

J Wilson Daddy

REGISTRAR'S SIGNATURE

VS. A15ME(5)

5M 9/55

BUREAU V. S.

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03161

03157

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 5 1/2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 4406 Woodfield Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4406 Woodfield Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FLORENCE		First	Middle	Last	4. DATE OF DEATH March 12,	Month	Day	Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1912	9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 16	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Holy Redeemer School		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME David M. Roach				14. MOTHER'S MAIDEN NAME Florence Hughes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT George A. Schanzenbach-Item# 2		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Respiratory failure (c)								
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Brooklyn (State) N.Y.		
21. I certify that I attended the deceased from 4/12 , 19 54 , to 3/12 , 19 57 , that I last saw the deceased alive on 3/12 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Florence R. Price ADDRESS (Street, city or town, state) 4615 Edgefield Rd. Kensington DATE SIGNED 3/12/57								
PHYSICIAN'S NAME (Type) Florence R. Price		M.D. 4615 Edgefield Rd. Kensington 3/12/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/15/57		22c. NAME OF CEMETERY OR CREMATORIAL Evergreen		22d. LOCATION (City, town, or county) Brooklyn, New York (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-16-67 24b. REGISTRAR'S SIGNATURE Benji M. Humprey						

BUREAU V. S.

MAR 1 1957

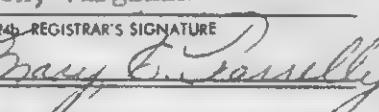
DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03165

03158

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 1 day															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park															
3. NAME OF DECEASED (Type or print) Joseph				First John	Middle SCHNEIDER	Last	4. DATE OF DEATH March	Month 30	Day 195	Year									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-30-57		9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1		IF UNDER 24 HRS. Days 1		Hours 0		Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Le Roy E. Schneider								14. MOTHER'S MAIDEN NAME Jan L. Godfrey											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (Father) LeRoy E. Schneider (Same As #2)				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Pneumonia												(b) Prematurity							
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 30 March 1957 to 30 March 1957 , that I last saw the deceased alive on 30 March 1957 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE 												DATE SIGNED 4-1-57							
PHYSICIAN'S NAME (Type) James C. Parke, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-3-57				22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery				22d. LOCATION (City, town, or county) Arlington, Virginia				(State)			
23. FUNERAL HOME James C. Parke, Jr. LT, MC, USN				ADDRESS 1100 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR 4-1-57				24b. REGISTRAR'S SIGNATURE 							

BUREAU V. S.

APR 3 1957

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0304S

CERTIFICATE OF DEATH

03159
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>9 hrs. 30 min.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium & Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holtsville</i>	
3. NAME OF DECEASED (Type or print) <i>First</i> <i>Euge</i>		4. DATE OF DEATH <i>Last</i> <i>Schwartz</i> Month <i>3</i> - Day <i>16</i> - Year <i>1957</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-24-17</i>	
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Ds <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. IF UNDER 24 HRS Months <i>0</i> Ds <i>0</i> Hours <i>0</i> Min. <i>0</i>		12. CITIZEN OF WHAT COUNTRY? <i>Mass.</i> 13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Sudack</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Soboloff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>014-09-4998</i>	
17. INFORMANT <i>Washington Sanitorium & Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3-4 weeks</i>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20b. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. (City or town)	
21. I certify that I attended the deceased from <i>Nov 4</i> , 1957, to <i>March 16, 1957</i> , that I last saw the deceased alive on <i>March 16, 1957</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>135-2 University City Lane</i> DATE SIGNED <i>Harold Sterling</i>			
22c. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <i>Harold Sterling</i>		22d. LOCATION (City, town, or county) (State) <i>Holtsville, Md.</i>	
22e. FUNERAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>3/17/57</i>	
22g. NAME OF CEMETERY OR CREMATORIUM <i>George Washington Cemetery</i>		22h. REG. NO. (If applicable) <i>4717-9457</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		24a. ADDRESS ADDRESS <i>4717-9457</i>	
24b. REC'D. BY REGISTRAR DATE <i>3/17/57</i>		24c. REGISTRAR'S SIGNATURE <i>J. L. Miller, R.D.H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGGIE

Y. V. REARU

MAR 15 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03049

CERTIFICATE OF DEATH

03160
773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 19 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 317 Fairhaven Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Wilfred	Middle Denham	Last Seal	4. DATE OF DEATH March 16	Month Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-01	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk		10b. KIND OF BUSINESS OR INDUSTRY Assoc. Amer. R. R.		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Alexander R. Seal		14. MOTHER'S MAIDEN NAME Annie Spick		12. CITIZEN OF WHAT COUNTRY? America	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input checked="" type="checkbox"/> WW I Army		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Peritonitis</i> DUE TO <i>587.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Necrosis of Stomach</i> DUE TO <i>2 days</i> (c) <i>Necrosis of L. M. C. to follow</i> DUE TO <i>2 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Ed. & ex. to General St. necrosis (Hemorrhagic) - 24</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-24</i> , 19 <i>57</i> , to <i>3-18</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3-15-57</i> , 19 <i>57</i> , and that death occurred at <i>12⁰⁰</i> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Arthur F Coyne</i> M.D. <i>760 Carroll Ave. Takoma Park, MD 20912</i> <i>3-16-57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 19, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Latourelle		ADDRESS 3619-14 th Street		24a. REC'D BY REGISTRAR DATE MAR 19 1957	
				24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dadds</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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the registrar prior to burial, in transit, or removal, and in any event within 72 hours after death.

BEREAU V. S

MAR 29 1967

RECEIVED

DEPARTMENT OF HEALTH—BALTIMORE, 18
 MARYLAND STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 03165 Reg. Dist. No. 214
 03161

This certificate should be executed within 4 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Part 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10117 Colesville Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS No known address		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel Henry Shorter		First	Middle	Last	4. DATE OF DEATH Mar 16, 1957	Month	Day	Year	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/ 1909	9. AGE (in years last birthday) 47	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) candy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Dell Shorter				14. MOTHER'S MAIDEN NAME Rosy C. Curry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Edith Marshall		357 Chapin St., S.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						Coronary occlusion			
						INTERVAL BETWEEN ONSET AND DEATH Found dead			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE	<i>Frank J. Broschart</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3/17/57		
EXAMINER'S NAME (Type)	Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3/17/57	22c. NAME OF CEMETERY OR CREMATORIAL John T. Rhines & Co Fun. Home			22d. LOCATION (City, town, or county) (State) 903 3rd St., Wash. D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.			24a. REC'D BY REGISTRAR Mar 19 1957	24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>			
VS. A15ME(5) 5M 9/55									

BUREAU V. S.

APR 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03167

CERTIFICATE OF DEATH

03162

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maitland	
3. NAME OF DECEASED (Type or print) First Fred Middle George Last Siegrist		d. STREET ADDRESS Box 120	
4. DATE OF DEATH March 11, 1957		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1930
9. AGE (In years at death) 26		10. FATHER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 7 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) New York		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Siegrist		14. MOTHER'S MAIDEN NAME Maud Twitzhingz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO WW II 264-52-6354	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Hemorrhagic pneumonia Acute lymphatic leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bacteremia		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 7, 1957</u> to <u>March 11, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>2:55 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE John László, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 3/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 3/12/57	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Winter Park (State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 3-14-67		24b. REGISTRAR'S SIGNATURE Decie S. Thompson	

RECEIVED

BUREAU V.

MAR 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03168 CERTIFICATE OF DEATH

03163

217

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician, to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington, D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>47x</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Queen</i>	Last <i>Slye</i>
4. DATE OF DEATH <i>March 1, 1957</i>	Month <i>March</i>	Day <i>1</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 28, 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Service (Retired) S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>S. Gov.</i>	11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Bess French Queen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>271-74-0000</i>	17. INFORMANT <i>Ella J. Henrick</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		Address <i>Batchelder's Forest Rd.</i>	
DUE TO <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 MIN</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Myocardial Dystrophy</i>		DUE TO <i>30 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. p. m.	Month a. p.m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>27 Feb.</i> , 19 <i>57</i> , to <i>28 Feb.</i> , 19 <i>57</i> that I last saw the deceased alive on <i>28 Feb.</i> , 19 <i>57</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Siegler, M.D.</i>	ADDRESS (Street, city or town, state) <i>Olney, Md.</i>		
PHYSICIAN'S NAME (Type) <i>JOHN B. SIEGLER</i>	DATE SIGNED <i>1 March 1957</i>		
22a. BURIAL, CREMATION, REMAINS (Specify) <i>3/4/57</i>	22b. DATE THEREOF <i>3/4/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cemetery</i>	22d. LOCATION (City, town, or county) <i>Washington, D. C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		ADDRESS <i>Wash. D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>1657</i>
		24b. REGISTRAR'S SIGNATURE <i>Gertrude B. Lawley</i>	

WILHELM V.

1925.2.27

WILHELM V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03050

03164

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		d. STREET ADDRESS <u>1000 3 Lorraine Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hospi</u>		d. STREET ADDRESS <u>1000 3 Lorraine Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Harvey</u>	Middle <u>Jessie</u>	Last <u>Smith</u>	4. DATE OF DEATH <u>3 - 9 1957</u>	Month <u>3</u>	Day <u>9</u>	Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-75</u>	9. AGE (in years last birthday) <u>81</u> yrs	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 HRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - mail service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mail service</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Ephraim Smith</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Rich</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chank</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> DUE TO <u>Rt. Hemiplegia and aphasia</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Generalized Arterio-Sclerosis</u> Undetermined DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Chronic Prostatism + Urinary retention</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D.</u>		20f. (City or town) <u>7835 Eastern Ave</u> (County) <u>Silver Spring</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Apr. 13, 1957</u> to <u>May 9, 1957</u> that I last saw the deceased alive on <u>May 7, 1957</u> and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>George L. Ball</u> ADDRESS (Street, city or town, state) <u>7835 Eastern Ave</u> <u>Silver Spring</u> <u>MD</u> DATE SIGNED <u>Mar 10 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL <u>3/12/57</u>		22b. DATE THEREOF <u>3/12/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) <u>DENVER, COLORADO</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren G. Humphrey,</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>3/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>McKeele</u>	

SCOTT V. S.

1957

SCOTT V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03165
217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg.			
Montgomery MARYLAND		Silver Spring			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Marion		First Marion	Middle Smith		
4. DATE OF DEATH Mar. 16, 1957		Month Mar.	Day 16		
5. SEX male		6. COLOR OR RACE col.			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1881			
9. AGE (in years at death) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			
17. INFORMANT Richard Hall		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar 19, 1957	
EXAMINER'S NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 3/21/57		22c. NAME OF CEMETERY OR CREMATORIAL Pilgrim Baptist		22d. LOCATION (City, town, or county) (State) Linden, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sanden</i>		ADDRESS Rockville, Md.		24. REG'D BY REGISTRAR DATE MAR 23 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
FEB 20 1977
FBI - BUREAU OF INVESTIGATION

BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03166

03170

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 INDIAN SPRING DRIVE			d. STREET ADDRESS 202 INDIAN SPRING DRIVE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First NELLIE	Middle HELEN	Last SMITH	4. DATE OF DEATH	Month MARCH 18 Day 19 Year 57
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/74	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) BOSTON, MASS.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PATRICK CARNEY			14. MOTHER'S MAIDEN NAME MARY KELLY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. C. Carney Smith, 202 Indian Spring Drive Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)			Address INTERVAL BETWEEN ONSET AND DEATH 7 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) Diabetes mellitus DUE TO (c) Generalized arteriosclerosis			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension and severe narrowing of left coronary		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on a foot stool in home on 2/29/1957		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 o. m. Jan 29 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Baltimore, Md.		(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 24</u> , 1957, to <u>Jan 29</u> , 1957, that I last saw the deceased alive on <u>January 17</u> , 1957, and that death occurred at <u>3:54 A.M.</u> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) M.D. 9210 Colesville Rd., S.S., Md.		
ACTUAL SIGNATURE Sydney Leventhal			DATE SIGNED 3/10/57		
PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.					
22a. BUR. AL. CREMATION REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 3/21/57		22c. NAME OF CEMETERY OR CREMATORIUM MAPLE HILL CEMETERY	
22d. LOCATION (City, town, or county) HARTFORD, MICHIGAN			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Clemente L. Humphrey, SILVER SPRING, MARYLAND			24a. REC'D BY REGISTRAR DATE 3/20/57		24b. REGISTRAR'S SIGNATURE Francis J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URÉAU V. G.
LIBRARY

MAR 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 212 3-22-57 ams

03167

03171

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived if not in or on Residence before admission) a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 ✓	
d. NAME OF HOSPITAL (If in hospital, give name of hospital or institution) The Clinical Center, National Institutes of Health, Bethesda, Md.		d. STREET ADDRESS 248 Hamilton St., N.W.	
3 NAME OF DECEASED (Type or print) James Bryan		4. DATE OF DEATH March 17 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 18 February 1952	
9. AGE (in years last birthday) 5 yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward W. Spink		14. MOTHER'S MAIDEN NAME Bernadette Couture	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 192X DUE TO <i>Respiratory and cardiac failure</i> INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Retinoblastoma</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 December, 1956, to 17 March, 1957, that I last saw the deceased alive on 17 March, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Glenn A. Drager</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Glenn A. Drager		DATE SIGNED 3-17-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAR 20 1957	
24b. REGISTRAR'S SIGNATURE <i>Lillian Thompson</i>			

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MAR 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03172

CERTIFICATE OF DEATH

03168

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS 3517-Bunning Island	
e. NAME OF DECEASED (Type or print)		First Marie	Middle M
f. SEX Female		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Washington D.C. U.S.
12. FATHER'S NAME Frederick Itahl		14. MOTHER'S MAIDEN NAME Catherine Kulpert	12. CITIZEN OF WHAT COUNTRY? Address 3517-Bunning Island
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Katherine Malone
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 175X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH ? month Adeno Carcinoma Ovary ? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcific aortic valve Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11-57 to 3-18-57, that I last saw the deceased alive on 3-17-57, and that death occurred at 121A M, from the causes and on the date stated above ACTUAL SIGNATURE Edward S. Witowsky, Jr. M.D. ADDRESS (Street, city or town, state) EDWARD S. WITOWSKY, JR. SUITE 400 8218 WISCONSIN AVE PHYSICIAN'S NAME (Type) BETHESDA 14, MARYLAND 3/18/57		RATE SIGNED	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/57	
22c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 3-21-57		24b. REGISTRAR'S SIGNATURE Jessie M. Thompson	

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MAR 10 1957

U.S. MAIL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03169

03173

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived—If institution, residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring					
3. NAME OF DECEASED (Type or print) First Mary		4. DATE OF DEATH Lost Stover Month March Day 21, 1957					
5. SEX Female		6. COLOR OR RACE White					
7. MARRIED W DOWED		8. DATE OF BIRTH September 20, 1908					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Insurance Company					
11. BIRTHPLACE (State or foreign country) Unascertainable		12. CITIZEN OF WHAT COUNTRY? Illinois U.S.A.					
13. FATHER'S NAME Paul Niles		14. MOTHER'S MAIDEN NAME Catherine McGovern					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO 349-14-9912					
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 100.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Liver		INTERVAL BETWEEN ONSET AND DEATH Lymphosarcoma involving cervical, mediastinal, abdominal lymph nodes + 5 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <u>March 21, 1957</u> , and that death occurred at 2:44 A.M., from the causes and on the date stated above.		ACTUAL SIGNATURE <i>William J. Pieper</i>		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/23/57		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Humphrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3-25-57		24b. REGISTRAR'S SIGNATURE <i>Bennie E. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03051 CERTIFICATE OF DEATH

03170

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 5½ days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6 SILVER SPRING	
3. NAME OF DECEASED (Type or print) First MARGARET		d. STREET ADDRESS 1223 NOYES DRIVE	
Middle THERESA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET		4. DATE OF DEATH MARCH 13 1957	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/83	
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lane		14. MOTHER'S MAIDEN NAME Margaret Dailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Charles B. Murto, 1223 Noyes Drive Silver Spring		Address INTERVAL BETWEEN ONSET AND DEATH 6 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Jan 1957</u> to <u>Mar 13, 1957</u> , that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred on <u>Mar 13, 1957</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>A. H. Richwine</u> M.D. <u>5522 Western Ave</u> DATE SIGNED <u>Mar 13</u> PHYSICIAN'S NAME (Type) <u>A. H. Richwine</u> <u>Cherry Chase 15, Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/15/57	
22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey,		24a. REC'D BY REGISTRAR DATE <u>3/14/57</u>	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE DATE	

BUREAU V. S.

MAR 17 1957

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03171

03174

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY <i>Indianhead</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 26 "D" Riverview Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lynn		First	Middle	Last	4. DATE OF DEATH MARCH 12 1957	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10 March 1957	9. AGE (In years last birthday) 2	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 2	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Billy Joe Taylor		14. MOTHER'S MAIDEN NAME Barbara Jane Langley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Billy J. Taylor, (Same As #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PULMONARY ATELECTASIS						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CEREBRAL ANOXIA						4.3 Hours			
DUE TO (c) PLACENTAL DYSFUNCTION									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.		20f. (City or town) U.S. Naval Hospital, Bethesda, Md.		(County) (State)	
21. I certify that I attended the deceased from 10 March 1957 to 12 March 1957 , that I last saw the deceased alive on 12 March 1957 , and that death occurred at 1:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-12-57									
ACTUAL SIGNATURE <i>Daniel Shuptar</i>									
PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-57		22c. NAME OF CEMETERY OR CREMATORIUM Camp Hill Cemetery		22d. LOCATION (City, town or county) Camp Hill, Alabama		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 755 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 3-12-57		24b. REGISTRAR'S SIGNATURE <i>Gray J. Tressel</i>			

RECEIVED

MAR 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03172

03175 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 mos. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X		d. STREET ADDRESS 950 25th St., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Grundy	Middle George	Last THOMAS	4. DATE OF DEATH	Month March	Day 4	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 14 Jan. 1911	9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Kirby S. Thomas				14. MOTHER'S MAIDEN NAME Lula B. Stinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes 1-19-34 to 5-28-46		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) metastases				INTERVAL BETWEEN ONSET AND DEATH 5 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5 Nov. 1956, to 4 March 1957, that I last saw the deceased alive on 4 March 1957, and that death occurred at 7:53 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE James E. Mc Lenathan Physician's Name (Type) James E. Mc Lenathan U.S. Naval Hospital, Bethesda, Md. 3-4-57 DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 3072 "M" St., N.W. Washington, D.C.				ADDRESS		24a. REC'D BY REGISTRAR DATE 3-4-57	
						24b. REGISTRAR'S SIGNATURE Bray E. Russell	

BRUNAU V. A.

17 1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03173

03176

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i> Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i> - Md. alt		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. STREET ADDRESS <i>Paradise</i>	
3. NAME OF DECEASED (Type or print) <i>Albert</i> First <i>Edwin</i> Middle <i>Thompson</i> Last		4. DATE OF DEATH Month <i>Mar.</i> Day <i>31</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 15 1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Yard</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Arline Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Clara Hebron, Port Republic, Md.</i>	
17. INFORMANT <i>—</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - neoplasm</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>5-10 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>March 25, 1957</i> to <i>March 31, 1957</i> , that I last saw the deceased alive on <i>March 25, 1957</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Miller</i> M.D. <i>9-13-1957</i> PHYSICIAN'S NAME (Type) <i>W.C. Miller</i> ADDRESS <i>600 3rd St. S.E. Washington, D.C.</i> DATE SIGNED <i>—</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/3/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Martinsburg</i>		22d. LOCATION (City, town, or county) <i>Martinsburg, Md.</i> (State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sowden</i>		ADDRESS <i>Rockville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 5 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Chas. Elgin</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 5 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03174

03177

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Olney		c. LENGTH OF STAY IN 1b 2 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery Gaithersburg	
3. NAME OF DECEASED (Type or print) Otho		d. STREET ADDRESS Rt. #1, Goshen Road	
4. DATE OF DEATH Month March		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/28/96		9. AGE (In years lost, birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Remus Trundle	
14. MOTHER'S MAIDEN NAME Margarettta		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. Mar 1		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to <i>Acute Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to <i>Myocardial Infarction</i> (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 18, 1957</u> to <u>Mar. 19, 1957</u> , that I last saw the deceased alive on <u>Mar. 18, 1957</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.			
22a. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.		22b. DATE THEREOF 3-22-57	
22c. NAME OF CEMETERY OR CREMATORIAL Burial		22d. LOCATION (City, town, or county) Arlington	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		24a. ADDRESS Gaithersburg, Md.	
24b. REC'D BY REGISTRAR DATE 3-21-57		24c. REGISTRAR'S SIGNATURE Bertrude B. Lawler	

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APR 1 1968

REGGAE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03175

03052 CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>George</u>	Middle <u>(IVMN)</u>	Last <u>URCIOLO</u>
4. DATE OF DEATH	Month <u>3</u>	Day <u>13</u>	Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-80</u>
9. AGE (In years (last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		Hours <u>0</u>	Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate (Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Paul (unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>old Records (Washington Sanat Hosp.)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertension & Cerebrovascular Accident (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1020 Old Bladensburg Rd</u>		20f. (City or town) (County) (State) <u>Colmar Manor Md</u>	
21. I certify that I attended the deceased from <u>Aug.</u> 1956, to <u>March</u> 1957, that I last saw the deceased alive on <u>May 13</u> , 1957, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1020 Old Bladensburg Rd 3-1357</u>			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u>		DATE SIGNED <u>3-13-57</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		M.D.	
220. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Science Funeral Home</u>		ADDRESS <u>3605-14th St. N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>J. Wilson, Eddy</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson, Eddy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03178

CERTIFICATE OF DEATH

Reg. Dist. No.

03176
297

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) James	First	Middle	Last	4. DATE OF DEATH March 24, 1957	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1918	9. AGE (In years last birthday) 38	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME James Walker	14. MOTHER'S MAIDEN NAME Nellie Sheppard	15. ADDRESS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
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PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		Uremia	INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Chronic Glomerulonephritis	Yrs

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15, 1957 to 3/24, 1957 , that I last saw the deceased alive on 3/23, 1957 , and that death occurred at 6:55 AM , from the causes and on the date stated above.
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ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE 	M.D. Sandy Spring, Md.	March 24, 1957
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Hopkins Chapel	22d. LOCATION (City, town, or county) (State) Highland, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE R. R. Snowden	ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE March 24, 1957	24b. REGISTRAR'S SIGNATURE Gertrude Lawless
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BUREAU Y. S.

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03177

03053

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Md.	
Towson Park		13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Washington Sanitarium Hosp. &al		105 W Franklin Ave			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Ernest		(Nmn)		Wardfield	Month
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 75 yrs.
Male		White		May 9 1881	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Procurement Division Worker		Inspector U.S. Gov't.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John F. Wardfield		Bazetta Ella Stunkle		United States	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)		None		Alice M. Wardfield - daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
- PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 4 months			
4. t. DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 1956, to <u>Mar 29</u> , 1957, that I last saw the deceased alive on <u>Mar 29</u> , 1957, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) M.D. 9601 Colleville Rd. Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORIUM CONGRESSIONAL CEMETERY	
22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Cecilie L. Remonday		ADDRESS SILVER SPRING, MD.		24a. REC'D. BY REGISTRAR 1957	
				24b. REGISTRAR'S SIGNATURE John S. Sodol	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

APR 3 1957

REGELYEGU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03178

03179

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove years		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F. D. Germantown		d. STREET ADDRESS R.F.D. Germantown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur L. Watkins		First	Middle
4. DATE OF DEATH March 16		Month	Day Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. BIRTHDATE April 5, 1885		9. AGE (In years from birth) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dairy Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Cedar Grove, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Watkins		14. MOTHER'S MAIDEN NAME Julia Linthicum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None	
17. INFORMANT No		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterosclerosis/Heart Disease 15 years DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (c)	
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1956, to <u>Mar. 16</u> , 1957, that I last saw the deceased alive on <u>Mar. 6</u> , 1957, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (TYPE) Jack Schmeacher, M.D.		ADDRESS (Street, city or town, state) 26 N. Summit Ave., 3-1857 Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 19, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Salem Methodist		22d. LOCATION (City, town, or county) Cedar Grove, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molsumth		24a. REC'D BY REGISTRAR DATE Mar 18 1957	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Della W. Burdell	

HOSPITAL DIRECTOR: The law requires that the death certificate be completed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

MAR - 12/74

50-1146

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03180

CERTIFICATE OF DEATH

03179

Reg. Dist. No. 2 17

1. PLACE OF DEATH a. COUNTY Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) St. Philomena Rest Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 41 Adams St. N.W.	
3. NAME OF DECEASED (Type or print) Francis		First C	Middle Webb
4. DATE OF DEATH March 11 1957		Month Day Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept, 27 1866		9. AGE (In years 190 yrs.) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Worshipful Co	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis I Webb		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Francis W. Webb		Address Silver Spring Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cerebrovascular DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953, 19, to 1957, 1, 1957, that I last saw the deceased alive on March 10, 1957, and that death occurred at 6 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE A.W. Smith PHYSICIAN'S NAME (Type) A.W. SMITH		ADDRESS (Street, city or town, state) 4601 16th St. NW Washington, D.C. DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14	
22c. NAME OF CEMETERY OR CREMATORIAL Laytonsville		22d. LOCATION (City, town, or county) Laytonsville	
23. FUNERAL DIRECTOR'S SIGNATURE Loyd B. Lawler		24a. REC'D BY REGISTRAR DATE 3-13-57	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Loyd B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03180

03181 CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please print carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 14 hrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. STREET ADDRESS Route I				
3. NAME OF DECEASED (Type or print) Baby		First Middle Last WHITE	4. DATE OF DEATH Month MARCH Day 10th Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9, 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME CARL L. WHITE		14. MOTHER'S MASTERN NAME MRS. HELEN J. McCONNELL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT FATHER - Route #1 - Clarksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 160.0		Address INTERVAL BETWEEN ONSET AND DEATH Pulmonary Atelectasis				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from MARCH 9, 1957, to MARCH 10, 1957, that I last saw the deceased alive on MARCH 10, 1957, and that death occurred at 9:05 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) R. H. Bergstrom, M.D., Rockville Med. Ctr., Rockville, Md. 3/10/57		DATE SIGNED 3/10/57
ACTUAL SIGNATURE R. H. Bergstrom		PHYSICIAN'S NAME (Type) R. H. Bergstrom, M.D., Rockville Medical Center, Rockville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/14/57		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Date 3-14-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V 6

MAR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03182

CERTIFICATE OF DEATH

03181
2/16

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 211 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
3. NAME OF DECEASED (Type or print) First Donald Middle Foster Last White		d. STREET ADDRESS 3830 N. 30th Road	
4. DATE OF DEATH March 5, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1915
9. AGE (In years last birthday 41 yrs.)		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Idaho		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Maude Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. WW II & peace-time 215-32-8714	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Malignant carcinoma, metastatic to liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>with resultant extensive hepatic parenchymal</i> (c) <i>Malignant carcinoma, primary in liver</i> <i>already surgically resected 1955</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1956, to March 5, 1957, that I last saw the deceased alive on March 5, 1957, and that death occurred at 9:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Allan H. Levy</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Allan H. Levy, M. D. The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 3/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/57	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat.		22d. LOCATION (C'ty, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 3-5-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU Y. S.

27 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03182

03183

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Manor Club Estates	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emma	Middle Barnsley	Last Williams
4. DATE OF DEATH	Month March	Day 7	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/18/76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Thomas Barnsley		14. MOTHER'S MAIDEN NAME Mary Willard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X <i>Intraluminal Obstruction</i> , DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Carcinoma Transverse Colon</i> DUE TO (c)		4 days 3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Olney (County) Maryland (State)
21. I certify that I attended the deceased from 3/2/57 to 3/7/57 that I last saw the deceased alive on 3/6/57 , and that death occurred at 2:00AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 3/7/57	
ACTUAL SIGNATURE <i>J. W. Bird</i>	M.D.		
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.	Sandy Spring, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/57	22c. NAME OF CEMETERY OR CREMATORIAL St. John's	22d. LOCATION (City, town, or county) Olney, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR 3-10-57	24b. REGISTRAR'S SIGNATURE Bertinda B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 15 1957

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03184

CERTIFICATE OF DEATH

031831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,301 Sherwood Forest Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) FLORA STEELE		d. STREET ADDRESS 3611 Prospect Street, N.W.	
4. DATE OF DEATH MARCH 14 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1880	
9. AGE (In years last birthday) 76 yrs.		10. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel R. Steele		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. James W. John, 13,301 Sherwood Forest Dr. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1+ years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		5+ years	
(b) DUE TO		20+ years	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heart block - complete		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 27, 1955, to March 17, 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 12:00 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Stephen Hulbert		ADDRESS (Street, city or town, state) M.D. 3000 Dent Place, Mt. Washington, Md.	
PHYSICIAN'S NAME (Type) R. Stephen Hulbert M.D.		DATE SIGNED Mar 17 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF March 14, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State) Kittanning, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Worrell E. Pumphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR DATE 3/19/57		24b. REGISTRAR'S SIGNATURE Frances Miller	

BUREAU V. S.

MAR 21 1957

REFUGEE

DUTY MEDICAL EXAMINER: This certificate should be executed within **1 hour** after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C3054

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03184
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>D.O.T.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. Acad. & Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>Harold (Frank) Wilson</i>		First <i>Frank</i>	Middle <i>(Frank)</i>
4. DATE OF DEATH <i>Mar 31 1957</i>		Last <i>Wilson</i>	Month Day Year
S SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-20-99</i>
9. AGE (In years last birthday) <i>57 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Eva ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Hosp. Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, If any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	DATE SIGNED <i>3-31-57</i>		
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>4/1/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Prince George Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Heiner Co. 2901-14th St. N.W.</i>	ADDRESS <i>APR 1 1957</i>	24a. REC'D BY REGISTRAR <i>1957 J. Williams</i>	24b. REGISTRAR'S SIGNATURE <i>J. Williams</i>

SUREAU V. E.

111-1157

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03/85

CERTIFICATE OF DEATH

03185

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 7217 Oakridge Avenue	
3. NAME OF DECEASED (Type or print) Sarah		4. DATE OF DEATH Month March Day 21, 1957 Year 57	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching	
10c. MOTHER'S NAME Harry Gordon		14. MOTHER'S MAIDEN NAME Esther Elkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 219-36-8319	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which give rise to immediate cause (a), writing the under- lying cause first (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hours - hantibacteris, Cophene a paralysant 5 years - metastatic carcinoma, widespread, of breast	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 1957, to March 21, 1957, that I last saw the deceased alive on March 21, 1957, and that death occurred at 9:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE William J. Pieper M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 3/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/57	
22c. NAME OF CEMETERY OR CREMATORIUM King David Memorial Garden		22d. LOCATION (City, town, or county) Falls Church, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Denzensky & Sons - 3801 14th St., N. W.		24a. REC'D BY REGISTRAR DATE 3-25-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU Y. S.

MAR 8 1962

REGISTRATION

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03055 CERTIFICATE OF DEATH

03186
773

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician and completely filled in by general director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital 5716 16th st. N.W.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 4112</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Wilbur Carl Wyatt</i>		First <i>Wilbur</i>	Middle <i>Carl</i>
4. DATE OF DEATH <i>3 13 1957</i>		Month <i>3</i>	Day <i>13</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3-8-74</i>		9. AGE (In years lost birthday) <i>83 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Government work of Personal Public Roads</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired-Director</i>	
11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Joseph Nicholas Wyatt</i>		14. MOTHER'S MAIDEN NAME <i>Parisa Parks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Chart</i>	
17. INFORMANT <i>Chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>few hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>(b) Compression of thoracic spinal cord</i>		few days	
DUE TO Carcinoma, metastatic from prostate <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar. 10</i> , 1957, to <i>Mar. 13</i> , 1957, that I last saw the deceased alive on <i>Mar. 12</i> , 1957, and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul V. Starr</i>		ADDRESS (Street, city or town, state) <i>M.D. 7600 Carroll Ave. 3-13-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>3/14/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>City</i>		22d. LOCATION (City, town, or county) (State) <i>Newbern, Tenn.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul V. Starr</i>		ADDRESS <i>1718 1/2 Carroll Ave. Washington D.C.</i>	
		24a. REC'D BY REGISTRAR <i>MAR 15 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dods</i>	

RECEIVED
BUREAU V. S.

MAR 12 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03187
 2/16

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)													
a. COUNTY		b. STATE Maryland b. COUNTY Montgomery													
Montgomery MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b													
Bethesda		27 days													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 9 Frederick Avenue													
Suburban Hospital		General Delivery													
e. IS RESIDENCE ON A FARM?															
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First Joyce		Middle Ann		Last Yokley		4. DATE OF DEATH		Month 3		Day 26		Year 19 57	
5. SEX		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/9/50		9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
Female				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						Months 0		Days 0		Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
child				Derwood, Maryland		U.S.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
James Yokley		Minnie Rebecca Page													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Rockville, Md.									
				James Yokley (father) 9 Frederick Ave.,											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kidney Insufficiency															
916.0 DUE TO (b) Extensive 3rd degree burns involving about 65% of body												1 month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour 4:30 p.m. 2/27/57		20d. INJURY OCCURRED at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) home		20f. (City or town) Rockville		(County) Montgomery		(State) Md.					
White <input type="checkbox"/> Not white <input type="checkbox"/>															
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 3/26/57													
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-57		22c. NAME OF CEMETERY OR CREMATORIAL Rockville Union		22d. LOCATION (City, town, or county) Rockville		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR 3-28-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILDCAT SWIMMING CELEBRATE 40 DEATH

BUREAU V. 2

APR 1 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03187 CERTIFICATE OF DEATH

Reg. Dist. No. 245
 03188

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1½ hours		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		
d. STREET ADDRESS 4348 N. Henderson Road			d. DATE OF DEATH March 28 1957		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby		First Boy	Middle ZSELECKZY	Last	Month Day Year March 28 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-57	9. AGE (In years last birthday) yrs. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Emil Jacob ZSELECKZY			14. MOTHER'S MAIDEN NAME Rosalind J. Waters		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Emil J. Zseleczky (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. Death was caused by: IMMEDIATE CAUSE (a) 757.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congenital hydrocephrosis hydranencephaly 75 mm (c) Prematurity					
INTERVAL BETWEEN ONSET AND DEATH 72 hrs					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 March 1957 to 28 March 1957 , that I last saw the deceased alive on 28 March 1957 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-29-57					
ACTUAL SIGNATURE John H. Mazur					
PHYSICIAN'S NAME (Type) JOHN H. MAZUR, LT, MC, USN					
U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey R.A. Humphrey, 7557 Wisconsin Ave., Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 3-29-57		
24b. REGISTRAR'S SIGNATURE Mary E. Farrell					

CERTIFICATE OF DATA

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

APR 1 1957

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